South Central Community Action Program
SCCAP
Empowering people to reach their potential

AFFIDAVIT FOR REPLACEMENT OF PERSONAL OR PET MEDICATION AND/OR MEDICALLY NECESSARY FOOD.

South Central Community Action Program

INSTRUCTIONS TO CLIENTS: If a replacement issuance is being requested you must complete this form, the application, and provide all documents within thirty (30) days of the loss. Allow at least two weeks for your application to be processed.

INSTRUCTIONS TO SCCAP: Provide one (1) copy to the participant or authorized representative.

PARTICIPANT AFFIRMATION

I, _____ , residing at: _____ ,
Full name of client *Household address (number and street, city, state, and ZIP code)*

hereby state that due to a household misfortune or natural disaster, personal or pet medications and/or medically necessary food was destroyed. I do understand that a household misfortune is a situation which my household had no control over such as weather related issues or power outages. Appliance malfunction or human error is not considered a household misfortune.

Telephone number where you can be reached ( )	Date the misfortune / disaster occurred *(month, day, year)*	Estimated value (personal or pet medications and/or medically necessary food lost)

Description of the misfortune / disaster

I request SCCAP to issue replacement personal or pet medications and/or medically necessary food. I understand that the amount of replacement benefits for which I am eligible will be determined by the date of loss, the amount of personal or pet medications and/or medically necessary food used and cannot exceed my monthly prescription already received.

AFFIDAVIT AND SIGNATURE

I affirm that the replacement of my personal or pet medications and/or medically necessary food loss is due to a misfortune / disaster and the amount of my loss is my best possible estimate. I understand if I knowingly give false or misleading information in order to become eligible for SCCAP benefits I may be prosecuted under all applicable state and federal laws.

I do solemnly swear (or affirm) under penalty of perjury that all statements made in the above request are true and correct to the best of my knowledge and belief. *(If participant affirms, the "swear" should be crossed out.)*

Signature of participant or authorized representative	Date *(month, day, year)*

Witness *(if signature is by "X")*

Address of witness *(number and street, city, state, and ZIP code)*

FOR SCCAP USE ONLY

❑ Date application received _____

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