

**ARKANSAS DEPARTMENT OF HUMAN SERVICES**  
***Supplemental Nutrition Assistance Program***

**DECLARATION OF STOLEN BENEFITS**

IF YOU NEED THIS MATERIAL IN A DIFFERENT FORMAT SUCH AS LARGE PRINT, PLEASE CONTACT YOUR LOCAL DHS COUNTY OFFICE.

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Last four of SSN: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date of theft discovery: \_\_\_\_\_

**Do you request a replacement EBT card before submitting this form?**

**If not, a replacement card must be issued.**

YES  NO

**Please provide the following information related to the stolen benefits:**

Was the card in your possession on the date you discovered your benefits had been stolen?

YES  NO

If no, please provide the date that you reported your EBT card lost/stolen: \_\_\_\_\_

Date of transaction: \_\_\_\_\_  
Retailer: \_\_\_\_\_  
Retailer Address \_\_\_\_\_  
Amount: \_\_\_\_\_  
FNS Number (State Agency only) \_\_\_\_\_

Date of transaction: \_\_\_\_\_  
Retailer: \_\_\_\_\_  
Retailer Address \_\_\_\_\_  
Amount: \_\_\_\_\_  
FNS Number (State Agency only) \_\_\_\_\_

Date of transaction: \_\_\_\_\_  
Retailer: \_\_\_\_\_  
Retailer Address \_\_\_\_\_  
Amount: \_\_\_\_\_  
FNS Number (State Agency only) \_\_\_\_\_

Narrative (Please provide a brief explanation of the reason for the replacement request):

***If this information is found to be incorrect, your eligibility and benefit level may be affected, and you may be subject to criminal prosecution for knowingly providing incorrect information.***

- My answers on this form are correct and complete to the best of my knowledge.
- I understand the penalties for hiding or giving false information.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**INSTRUCTIONS DCO-0238F**

**Purpose**

The DCO-0238F is used by households to request replacement of benefits for benefits stolen due to card skimming, card cloning, or another similar fraudulent method.

**Completion**

The client should complete the form. If the client cannot complete the form, the worker may complete the form based on the household's statements. The client must sign (wet or electronic) and date the form.

**For Agency Use Only Instructions**

- A. **Instructions for retrieving the FNS number:** To retrieve the FNS number, review the transaction history in the EBT system according to the information provided.

**Routing**

The original copy should be scanned into the electronic case record. A copy may be given to the client upon request.

**Retention**

Five years from date of origin.