AFFIDAVIT OF RETURN OF FOOD OR CASH BENEFITS

Month: _____

Name: _____

Address: _____

Phone* _____

*We will contact you if we are unable to process this EBT payment

Case Number _____Social Security_____

Dollar amount to remove from EBT_____

Value written _____dollars and _____0_____cents

Type of Benefit (circle one) FOOD CASH

This action is taken pursuant to Colorado Department of Human Services Staff Manual Volume III, Section 3.860 Protections to the Individual and Volume IV-B, Section B-4800 Electronic Benefits Transfer (EBT) and the Special Projects Staff Manual Section 12.100.

Boulder County Department of Housing and Human Services may disclose this information, without written consent of the individual, to other Federal, State or Local authorities responsible for administering or enforcing the program, which may lead to the undertaking of investigations, or the bringing of civil lawsuits or criminal prosecution. In addition, Boulder County may disclose information to a court, magistrate, or administrative tribunal when required in civil or criminal proceedings.

_____ _____

Signature of the Person Returning Benefits Date

_____ _____

Signature of Witness Date

PLEASE NOTE

This is a one-time only EBT payment. All future EBT payments require a new form.

AP-607