DIS 14
Issued 09/24

Louisiana Department of Children and Family Services

DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
AFFIDAVIT OF DISASTER LOSS

Name (Head of Household): _____

Social Security Number: _____

Household Address: _____

City/Town/State/Zip code: _____

Parish: _____

SUPPLEMENTAL BENEFITS REQUEST

I certify under penalty of perjury that my household experienced one or more adverse effects (loss of income, inaccessible liquid resources, or out of pocket, unreimbursed disaster-related expenses) as a result of Hurricane Francine that occurred in my parish of residence from September 9, 2024 (the date that evacuation orders were issued) through October 8, 2024. I understand that I will be subject to disqualification and prosecution and will be required to repay ineligible benefits if I knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain food assistance.

Adverse Effect (Please explain): _____

_____

Client Signature: _____

Date: _____

Please provide collateral contact information in order for the State agency to verify your loss. Depending on the availability of power outage data or flood maps to verify your loss, the State agency may decide collateral contact information is not necessary.

Name of Collateral Contact: _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____