INSTRUCTIONS
DHS 1009
REPORT OF STOLEN ELECTRONIC BENEFITS FORM

PURPOSE:

The DHS 1009 shall be used to verify a claim for replacement benefits for households victimized by electronic benefit theft through card cloning, card skimming, or similar fraudulent methods in accordance with Hawaii Administrative Rule (HAR) §17-685.

GENERAL INSTRUCTIONS:

A household may be eligible to receive a replacement of financial assistance, SNAP benefits, or a supportive service payment by submitting the DHS 1009 within ten (10) business days from the date the household reported the electronic benefits theft to the department and there is sufficient evidence to determine the theft.

SPECIFIC INSTRUCTIONS:

Before completing this form, please be aware of the date filled in the section labeled: "**Return no later than**". Be sure to submit the completed DHS 1009 form on or before that date.

Complete all four (4) section of the DHS 1009 form.

1. **Section A – Case Information:** The primary account holder shall complete the necessary information. The name of alternate payee and name of authorized representative fields may be left blank as it applies only to the household.

2. **Section B – Information On Benefits:** The primary account holder shall complete this section to the best of their knowledge as is applies to his/her claim. If more space is needed, please use a blank sheet of paper.

3. **Section C – Last Known Benefits Transactions:** The primary account holder shall complete this section to the best of their knowledge.

4. **Section D – Certification:** The primary account holder shall complete the applicable sections as indicated by the check box as well as initial each statement confirming his/her review and acknowledgement.

STATE OF HAWAII
Department of Human Services (DHS)
Benefit, Employment and Support Services Division

OFFICE USE:
Return no later than: _____
Case #/Client ID:

REPORT OF STOLEN ELECTRONIC BENEFITS

A. CASE INFORMATION (to be completed by the Primary Account Holder):

Name: _____ Phone: _____

Mailing Address: _____ Last 4 digits of SSN: _____

_____ Last 4 digits of EBT card: _____

Name of Alternate Payee: _____ Case/Client No.: _____

Name of Authorized Representative: _____ Household Size: _____

B. INFORMATION ON BENEFITS THEFT:

Total SNAP Amount Stolen: $ _____ Date(s) when theft(s) were discovered: _____

Total Cash Amount Stolen: $ _____ Date(s) when theft(s) were discovered: _____

Date of Stolen Benefit Transaction	**Transaction Amount**	**SNAP or Cash Transaction**	**Retailer Name:**	**Type of Purchase** (Online, Mag Stripe, Card not present, ATM)

C. LAST FOUR (4) KNOWN BENEFITS TRANSACTIONS COMPLETED BY HOUSEHOLD:

Date of Transaction	**Transaction Amount**	**SNAP or Cash Transaction**	**Retailer Name:**	**Type of Purchase** (Online, Mag Stripe, Card not present, ATM)

D. CERTIFICATION (to be completed by Primary Account Holder):

The following **CERTIFICATION** section must be completed by indicating which program(s) have been affected. Check the box and initial all responses as applicable. The **ALL programs** section is required and must be reviewed and initialed. The claim must be signed and dated on page 2 to be considered a completed claim.

☐ Please read and initial the following statements as it applies to **SNAP benefits**.

Initials:

1. _____ I have attached copies of documents verifying that my SNAP benefits have been stolen via fraudulent methods. Do NOT include any benefits that were used by other SNAP household members or alternate payees.
2. _____ I understand that replacement benefits cannot be more than the actual amount of the benefits stolen or the amount of two months of Hawaii SNAP benefits, whichever is less.
3. _____ I understand that benefit replacements can only be claimed for thefts that occurred between 10/1/2022 through 9/30/2024.

☐ Please read and initial the following statements as it applies to financial benefits including **Temporary Assistance for Needy Families**, **General Assistance**, and **Aid to Aged, Blind, and Disabled.**

Initials:

1. _____ I have attached copies of documents verifying that my financial benefits and/or supportive services payments have been stolen via fraudulent methods.
2. _____ I understand that replacement benefits cannot be more than the actual amount of benefits stolen or the amount of two months of financial benefits, whichever is less.

☐ Please read and initial the following statements as it applies to supportive services payments including **Child Care Subsidy**, or **First-To-Work** programs.

Initials:

1. _____ I have attached copies of documents verifying that my financial benefits and/or supportive services payments have been stolen via fraudulent methods.
2. _____ I understand that replacement benefits cannot be more than the amount of benefits determined by the department or the value of one month of the supportive service payment, whichever is less.

☐ Please read and initial the following statements as it applies to **ALL programs**—**SNAP**, **financial assistance**, **Child Care Subsidy** and **First-To-Work programs**.

Initials:

1. _____ I understand that the electronic benefits theft must be reported timely, within thirty (30) days from the date the theft was discovered.
2. _____ I understand that this form must be completed, signed, and returned to DHS within ten (10) business days of my report of the theft.
3. _____ I understand there is a limit to the amount of stolen benefits that may be replaced.
4. _____ I understand that benefits stolen due to electronic theft cannot be replaced more than two (2) times in a federal fiscal year (October – September).
5. _____ I understand that my existing EBT card will be cancelled, and I will receive a new card.
6. _____ I understand DHS will validate the claim of electronic theft through EBT processor data, retailer data, identified skimming devices, statements from customers, or other similar information.
7. _____ I certify that all information as stated is true and correct and I will be subject to repayment of any overpayments or penalties if I am found to have committed fraud.
8. _____ I understand that I have the right to an Administrative Hearing if I disagree with the department's denial of a claim for replacement of stolen benefits or the amount of the replacement benefits as determined under HAR §17-685-5.

_____ _____

Signature: Primary Account Holder **Date signed**