COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support
Phone: 855-306-8959 Fax: 502-573-2007

Date:
Case Number:

AFFIDAVIT

Case Name ______________________________ Check No.[Number] ______________

Address of Original Check ______________________________

____

County ______________________________

Amount of Check $______________ Date Processed [of Issuance] ______________ Type of Check ______________

Worker Name/Issued By ______________________________ [County ______________]

I. COMPLETE THIS SECTION FOR LOST OR STOLEN CHECKS:

I, ______________________________ (Payee), do solemnly swear under penalty of perjury (KRS 523.030), that I did not receive the ______________ check in the amount of $______________

made payable to ______________________________

for the month of ______________, 20__________.

I swear that if I find the lost check, I will return it immediately to the Department for Community Based Services (DCBS). I know that cashing both the original check and a replacement check is against the law and I will be prosecuted for doing so.

I swear I will repay the Treasurer of the Commonwealth of Kentucky for any loss to the State caused by the issuance of this replacement check, if it is proved that I also cashed the original check.

Therefore, I request a replacement check be issued.

I understand I have the right to talk to an attorney prior to signing this form.

______________________________ (Signed Payee) ______________ (Date)

Sworn and subscribed to before me on this ______________ day of ______________, 20______,

by ______________________________ (Name of Payee).

______________________________ by authority of KRS 205.170(1) and 921 KAR 2:060
(Designated Individual Signature)

OR

______________________________ My Commission Expires: ______________
(Notary Public Signature)

II. COMPLETE THIS SECTION FOR A LOST OR STOLEN CHECK THAT WAS CASHED:

I, ____, do solemnly swear that I am the payee or an official
(Payee)
representative of the payee, named on check number ________________________ dated ____________________

for $__________________.

I state, under penalty of perjury (KRS 523.030), the endorsement appearing on the above numbered check is not my signature, nor to my knowledge the signature of any individual or any organization acting on my behalf or on behalf of the organization. I further swear that I/my organization have received no benefit from the cashing of the above numbered check from any person.

I will assist any authorized persons in ascertaining the name or names and whereabouts of the person or persons guilty of forging my/my organization's name and will appear as a witness for the Commonwealth of Kentucky in any legal action against an alleged forger.

I swear that I will repay the Treasurer of the Commonwealth of Kentucky for any loss to the State caused by the issuance of this replacement check, if it is proved that I also cashed the original check.

Therefore, I request a replacement check be issued.

I understand I have the right to talk to an attorney prior to signing this form.

____ _________________________
(Signed Payee) (Date)

Sworn and subscribed to before me on this _____________ day of____________________, 20________________

by ____.
(Name of Payee)

____ My Commission Expires__________________
(Notary Public Signature)

III. WORKER SUMMARY:

This institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, [sex and in some cases religion and] political beliefs, or reprisal or retaliation for prior civil rights activity.

[The U.S. Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)]

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, [Director,] Office of Secretary for Civil Rights [Adjudication], 1400 Independence Avenue, S.W., Stop 9410, Washington, D.C. 20250-9410, by fax (833) 256-1665 [(202) 690-7442] or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm .

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: [HHS Director,] Office for Civil Rights, [Room 515-F,] 200 Independence Avenue, S.W., H.H.H. Building, Room 509-F, Washington, D.C. 20201 or call 1-800-368-1019 [(202) 619-0403 (voice)] or (TTY) 1-800 [(800)] 537-7697 [(TTY)].

USDA and HHS are equal opportunity providers and employers.

You may also file your complaint with the Cabinet for Health and Family Services, Office of Human Resource Management, EEO Compliance Branch, 275 East Main Street, 5C-D, Frankfort, Kentucky 40621, or call (502) 564-7770 EXT. 4107.

If you have other complaints about your case, you may call the Office of the Ombudsman and Administrative Review [Ombudsman's office] at 1-800-372-2973 or (TTY) at 1-800-627-4702.