



STATE OF MINNESOTA DEPARTMENT OF VETERANS AFFAIRS



20 West 12th Street • St. Paul, Minnesota 55155 • (651) 296-2562
 Fax (651) 296-3954 • MinnesotaVeteran.org • 1-888-LinkVet

MDVA-1A APPLICATION FOR DISASTER RELIEF

Date of Application:		Applicant's Email Address:	
CVSO Name (if applicable):		County:	
Disaster Event: 2020 COVID-19		Grant Amount: \$1,000.00	
<u>Applicant</u>			
Veteran <input type="checkbox"/>		Surviving Spouse <input type="checkbox"/>	

Section 1 RESIDENCY

Applicants must submit a copy of a valid MN Driver's License or Identification Card, or some other proof of Minnesota Residency. Applicants must have been a resident on 3/13/2020.					
RESIDENCE AT TIME OF DISASTER			CURRENT MAILING ADDRESS (if different)		
Street Address		Apt. #	Street Address		PO Box # Apt. #
City	State	Zip Code	City	State	Zip Code
Telephone Number			If mailing address is different from residence, please explain:		

Section 2 VETERAN INFORMATION

SSN		
Last Name	First Name	MI
Date of Birth	Place of Birth (City & State)	
Date of Death (If Deceased)	Place of Death (City & State)	
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated, living apart <input type="checkbox"/> Never Married		
Date of Marriage	City & State of Marriage	
Date of Separation/Divorce	City & State of Separation/Divorce	

AUTHORIZATION FOR RELEASE OF INFORMATION

MINNESOTA DEPARTMENT OF VETERAN AFFAIRS, 20 WEST 12TH STREET, ST. PAUL, MN 55155
 PHONE: (651) 296-2562 FAX (651) 296-3954

To	Name	
	Address	
	Veteran's SSN	Spouse's/Applicant's SSN
Information Requested From: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Childcare Provider <input type="checkbox"/> Independent School District <input type="checkbox"/> Applicant's employer <input type="checkbox"/> MN Department of Human Services <input type="checkbox"/> Other _____		
Information Requested:		
This authorization gives express authority to the Minnesota Department of Veterans Affairs to obtain from and exchange information with any of the organizations listed above in order to verify eligibility for the Disaster Relief Grant.		
Provisions of the State Data Privacy Act under Minnesota Statutes A. Information collected through the use of this release may be used and disseminated to individuals or agencies specifically authorized access to that data by state, local or federal laws subsequent to the collection of the data. B. Data collected may be used by and disseminated to any person or agency if you give informed consent. C. This release will expire one (1) year from the date of your signature. D. Information will be used to determine your initial and continued eligibility for state veterans' benefits administered by the Minnesota Department of Veterans Affairs. E. You may refuse to sign this release of information form; however, such refusal will result in a denial of your claim for lack of supporting information. F. This is notice to you as required by the Right to Financial Privacy Act of 1978 that the Minnesota Department of Veterans Affairs has a right to access financial records held by financial institutions in connection with the consideration or administration of assistance to you. Financial records involving your transactions will be available to the Minnesota Department of Veterans Affairs without further notice or authorization but will not be disclosed or released by the Minnesota Department of Veterans Affairs to another government agency or Department without your consent except as required or permitted by law.		
I have read and I understand the conditions of this release of information as stated on this form and hereby authorize the above named person, employer, corporation, society, organization, government agency or department, financial institution, hospital or physician, as stated above, to disclose the requested information to the Minnesota Department of Veterans Affairs.		
Veteran's/Surviving Spouse's Signature		Date

Upon request, this document will be made available in an alternative format. Write to address at the top of this form. TTY/TDD users should contact the Minnesota Relay Service at (651) 297-5353 in the Metro Area or 1-800-627-3529 in greater Minnesota.



PLEASE COMPLETE AND RETURN TO:
Minnesota Management & Budget
Vendor File Maintenance
400 Centennial Building
658 Cedar Street
St. Paul, MN 55155
Fax: (651) 797-1306
Vendor.mmbefax@state.mn.us

SUBSTITUTE FORM W-9

Name (DBA) and Physical Address:

Date: _____

Supplier Number (if known): _____

SUBJECT: Request for Taxpayer Information. (Failure to furnish a taxpayer identification number makes you subject to a penalty of \$50.)

The purpose of this form is to obtain or confirm your correct taxpayer name and identification number. Federal and state tax regulations require that we have this information from recipients of certain payments in order to report such payments to the Internal Revenue Service on the Form 1099 Return.

Please complete items 1, 2, and 3 below. If you have any questions, phone (651) 201-8201 for assistance. Send, fax or e-mail the completed form to the address in the upper right corner.

1. Check your tax filing status below and enter your social security number or federal employer identification number. If you have been issued a separate Minnesota tax identification number, write it in the space provided. If you have recently applied for a taxpayer number, write "Applied For" in the space for the number.

<p>(Check One)</p> <p><input checked="" type="checkbox"/> Individual/Sole Proprietor: Use SSN</p> <p><input type="checkbox"/> Limited Liability Company (Select One)</p> <p> <input type="checkbox"/> Single Member LLC: Use SSN</p> <p> <input type="checkbox"/> Partnership</p> <p> <input type="checkbox"/> C-Corporation (C-Corp)</p> <p> <input type="checkbox"/> S-Corporation (S-Corp)</p> <p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Trust/Estate</p> <p><input type="checkbox"/> Tax Exempt: Use FEIN and list the organization's IRS Exempt Payee Code (if any) _____</p> <p><input type="checkbox"/> Other: _____</p>	<p>_____</p> <p>SOCIAL SECURITY NUMBER (SSN)</p> <p>_____</p> <p>FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)</p> <p>_____</p> <p>MINNESOTA TAX ID NUMBER (IF APPLICABLE)</p>
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2. Print the full Legal/Withholding name belonging to the social security number or employer identification number provided above.

3. Certification. Under penalty of perjury, I certify the number shown on this form is my correct taxpayer identification number.

Signature: _____ Phone No: _____ Date: _____

Email Address: _____

PRIVACY ACT NOTICE - Internal Revenue code Section 6109 requires you to furnish your correct taxpayer identification number to payers who must file information returns with IRS. IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. Payers must generally withhold 28% of taxable interest and certain other payments to a payee who does not furnish a TIN to a payer.