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-1B APPLICATION FOR DISTANCE LEARNING SUPPORT GRANT

| Date of Application: | Applicant's Email Address: |
|---|---|
| **CVSO Name (if applicable):** | **County:** |
| **2020 COVID-19 DISTANCE LEARNING SUPPORT GRANT** | **Grant Amount: $3,000.00** |
| **Applicant** | |
| Veteran | Surviving Spouse |

## 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 8/1/2020.**

| PHYSICAL ADDRESS | | | CURRENT MAILING ADDRESS (if different) | | |
|---|---|---|---|---|---|
| Street Address Apt. # | | | Street Address PO Box # Apt. # | | |
| City | State | Zip Code | City | State | Zip Code |
| Telephone Number<br>(        ) | | | 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) | |

☐ Married ☐ Widowed ☐ Divorced ☐ Separated, living apart ☐ Never Married

| Date of Marriage | City & State of Marriage |
|---|---|
| Date of Separation/Divorce | City & State of Separation/Divorce |

## Section 3 SPOUSE / SURVIVING SPOUSE / DEPENDENT INFORMATION

| Last Name | First Name | MI | SSN |
|---|---|---|---|
| | | | |

| Date of Birth | Place of Birth (City & State) | Date of Death (If Deceased) | Place of Death (City & State) |
|---|---|---|---|
| | | | |

Is the spouse also a Veteran?

☐ YES ☐ NO

***Please list all dependents whom have had qualifying expenses related to the grant expended (not required to list more than three qualifying dependents)***

| Last Name | First Name | MI | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**By signing below, I certify that I understand the information provided by me to the Minnesota Department of Veterans Affairs will allow the Minnesota Department of Veterans Affairs access to information may be classified as private or confidential data under Minnesota Statute Chapter 13. The purpose of the collection of this information is to assist in processing the application for disaster relief. No other use, unless specifically authorized by law, will be made of this information without my prior written consent. I understand that I am under no obligation to supply the information requested, however, since eligibility cannot be determined without providing such information, the consequences of such refusal would make me ineligible.**

| Veteran's/Surviving Souse's Signature | Date Signed |
|---|---|
| | |

## Section 4 QUALIFYING ELIGIBILITY CRITERIA

**Please indicate which qualifying eligibility criteria you are applying under:**

☐ A parent had to reduce or eliminate work in order to accommodate the implementation of distance learning for their child

☐ The child was newly enrolled in a private school, daycare setting, homeschooling program, or similar business in order to accommodate their parent's employment and to facilitate the school district's current learning implementation of distance learning or hybrid modality for their child

☐ The parent has newly employed a tutor, nanny, non-parental family member, or other similar arrangement to coach, mentor, and implement distance learning for their child.

## Section 5 Demonstration of Negative Financial Impact Statement

**Briefly describe how you have suffered a negative financial impact as a result of implementation of distance learning or hybrid program:**

## 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:** ☐ **Healthcare Provider** ☐ **Childcare Provider**
☐ **Independent School District** ☐ **Applicant's employer** ☐ **MN Department of Human Services**
☐ **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.

# 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.**

| (Check One) | |
|---|---|
| [X] Individual/Sole Proprietor: Use SSN | |
| [ ] Limited Liability Company (Select One) | |
|   [ ] Single Member LLC: Use SSN | ________________ |
|   [ ] Partnership | SOCIAL SECURITY NUMBER (SSN) |
|   [ ] C-Corporation (C-Corp) | ________________ |
|   [ ] S-Corporation (S-Corp) | FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) |
| [ ] Corporation | ____________ |
| [ ] Trust/Estate | MINNESOTA TAX ID NUMBER (IF APPLICABLE) |
| [ ] Tax Exempt: Use FEIN and list the organization's IRS Exempt Payee Code (if any) __________ | |
| [ ] Other: ____________________ | |

**2. Print the full <u>Legal/Withholding</u> 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.**