



GOVERNMENT OF THE COMMONWEALTH OF DOMINICA

COVID-19 RESPONSE: LIVELIHOOD GRANT ASSISTANCE RE-SUBMISSION FORM

Please fill out if you are still unemployed

I hereby apply for continuation of COVID-19 Livelihood Grant

I am: Employee Self Employed

Title: Mr. Mrs. Miss.

First Name: _____

Middle Name: _____

Last Name: _____

Social Security Number: _____

Mobile No: _____ Email: _____

Last date unemployed: _____(dd/mm/yyyy), (or business was closed)

I have NOT received any OTHER INCOME

I have received OTHER INCOME

OTHER INCOME Amount \$ _____ for the month(s) of _____

I already received COVID-19 Livelihood Grant Amount \$ _____

I have NOT received COVID-19 Livelihood Grant

DECLARATION OF TRUTH (Employee)

A MATERIAL OR FALSE STATEMENT OR OMISSION MADE IN CONNECTION WITH THIS APPLICATION IS SUFFICIENT CAUSE FOR DENIAL OF THE INCOME SUPPORT GRANTS.

I swear or affirm that I have recently been LAID-OFF or TERMINATED and that I have read and understood all of the questions in this application and that all of the foregoing information and statements submitted in this application and its attachments and supporting documents are true and correct to the best of my knowledge, and that all responses to the questions are full and complete, omitting no material information. I recognize that the information submitted in this application is for the purpose of receiving income support grants from the Government of the Commonwealth of Dominica through the Dominica Social Security (DSS). I understand that the DSS may, by means it deems appropriate, determine the accuracy and truth of the statements in the application, and I authorize such

agency to contact any certifying agencies for the purpose of verifying the information supplied and determining the my eligibility.

I agree to provide written notice to the DSS of any material change in the information contained in the original application within seven (7) calendar days of such change.

I acknowledge and agree that any misrepresentations in this application will be grounds for denial or immediate revocation of benefits.

I declare, under penalty of perjury, that the information provided in this application and supporting documents is true and correct.

Do you agree: *

- Yes, I do agree
- No, I do not agree

Sign (Initials): *

Your answer

Date *