



Government of the Republic of Trinidad and Tobago
The Ministry of Labour and Small Enterprise Development (MOLSED)
in collaboration with
The Ministry of Social Development and Family Services (MSDFS)

FORM A-EMPLOYER/EMPLOYEE

APPLICATION FORM FOR SOCIAL ASSISTANCE FOR PERSONS WHO EXPERIENCE LOSS OF OR REDUCED INCOME IN RESPECT OF THE COVID -19 VIRUS

The Ministry of Labour and Small Enterprise Development (MOLSED) in collaboration with the Ministry of Social Development and Family Services (MSDFS), in response to Government's initiatives to mitigate the social and economic effects related to the spread of 'COVID 19' in Trinidad and Tobago, especially as they impact upon the most vulnerable among us, is requesting from employers the under-mentioned information on behalf of employees, so affected, in your organisation/business. Employees must be Citizens or Permanent Residents of Trinidad and Tobago.

To complete this form with the agreement of your employees, they must have been either Retrenched, Terminated or had their Income Reduced on or after **March 1st, 2020**.

To ensure that the application is processed speedily, please enclose copies of the following documents with the completed assessment/declaration form:

1. National Identification (**NOT** Driver's Permit or Passport) for each affected employee;
2. For non-national, Certificate of Registration;
3. Certificate of Registration/Incorporation of the employer;

4. Where there are employed members of the family, apart from the applicant, proof of actual earnings must be submitted such as a payslip and job letter.
5. For rental assistance, applicants are required to submit a rental agreement, evidence of most recent payment and a copy of the landlord's or landlady's ID Card (payment will be made directly to the landlord or landlady).

The completed form along with the aforementioned documents, shall be **submitted via e-mail only** to the undermentioned email addresses relevant to your area:

- supportforyou.east@gov.tt (Barataria/Blanchiessuse to Toco)
- supportforyou.north@gov.tt (Morvant to Maraval/Las Cuevas/Diego Martin/Petit Valley/Chaguaramas)
- supportforyou.central@gov.tt (Chase Village; Caroni; Felicity; Chaguanas; Tabaquite; Manzanilla; Couva; Talparo; Freeport; Claxton Bay and surrounding areas)
- supportforyou.south@gov.tt (Pointe-a-Pierre to Moruga/Icacos/Rio Claro/Guayaguayare)

When submitting the completed application by email, please ensure that the **SUBJECT** is sent in the following format:

Area/First Name/Last Name /Identification Number for example:

- **North/Janice/John/19741503421 for employee OR**
- **Area/Employer Name for employer**

TO AVOID DELAYS IN THE PROCESSING OF YOUR APPLICATION, PLEASE UTILISE THE GUIDELINES AS PROVIDED)

NOTE: ONLY ONE APPLICATION SHOULD BE SUBMITTED ON BEHALF OF AN EMPLOYEE

SECTION 1 – GENERAL INFORMATION ON EMPLOYER

Authorised Person																					
Job Title																					
Legal Name of Business																					
Contact Person /Authorised Person (CEO/Managing Director)																					
Business' Legal Registration No.	<table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																				
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E-mail																					
Website (if applicable)																					
Business Address/Mailing Address																					
Regional Corporation																					
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SECTION 2 – BUSINESS INFORMATION

1. Describe your MAIN business activities.			
2. What is the structure of your business? CHOOSE ONE ONLY.			
Sole Trader	Partnership	Corporation	
Cooperative	Joint Venture	Limited Liability co.	
Other (specify)			
3. Number of Affected Employees	Part-time	Full-time	Total

SECTION 3 – EMPLOYEE INFORMATION

TO BE COMPLETED BY ALL APPLICANTS

	APPLICANT
Name	
Gender	Male Female
National Identification Card No.	
Employment Classification	RETRENCHED TERMINATED INCOME REDUCED EFFECTIVE DATE:
Assistance being sought	PUBLIC ASSISTANCE GRANT <input type="checkbox"/> RENTAL ASSISTANCE GRANT <input type="checkbox"/> TEMPORARY FOOD CARD SUPPORT <input type="checkbox"/>

National Insurance No.	
Job Title	
Contact No.	
Email Address	
Home Address	
Proof of Citizenship/Permanent Residence	
Name of Bank and Branch	
Account Number	

Household Income							
Name	Gender	Relationship to Applicant	Date of Birth	Age	Employment Status	Total Income	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11	Total						
12	Total Income before Retrenchment/Termination/Reduction in Income						
13	If Line 11 is Equal to or LESS than \$10,000						Tick ()
14	If Line 11 is MORE than \$10,000						Tick ()

DECLARATION

I, the undersigned, hereby declare that the particulars I have supplied are true and complete.

Employee Name: Signature of Employee: Date:

Employer Name: Signature of Officer: Date:

FOR OFFICIAL USE ONLY: ____ VERIFIED ____ NOT VERIFIED

Officer Name: Signature of Officer: Date

VERIFICATION (Ministry of Labour and Small Enterprise Development)

To: The Permanent Secretary, Ministry of Social Development and Family Services

The details of the application submitted by the person listed hereunder have been verified. The application is forwarded for consideration for a grant by your Ministry.

Applicant's Name: ID No.

Date referred for endorsement of verification _____

Verification Endorsed

Verification not Endorsed

Officer Name: Official Position Signature of Officer:

Date:

ACKNOWLEDGEMENT (Ministry of Social Development and Family Services)

This is to certify that an assessment to determine your eligibility for a grant was completed. You are advised that you

(1) met the requirement for a grant

(2) did not meet the requirement for a grant because of the following

Applicant's Name: ID No.

Officer Name: Official Position Signature of Officer:

Date:

SECTION 5 – DECLARATION OF TRUTH (Employee)

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

I _____ (*full name*), swear or affirm that I have recently been **RETRENCHED** **TERMINATED** or had my **INCOME REDUCED** while in the employ of _____ (*Business Name*) 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 recognise that the information submitted in this application is for the purpose of social

services support by a government agency. I understand that a government agency may, by means it deems appropriate, determine the accuracy and truth of the statements in the application, and I authorise such agency to contact any certifying agencies for the purpose of verifying the information supplied and determining the named applicants' eligibility.

I agree to provide written notice to the recipient agency of any material change in the information contained in the original application within 30 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.

Signature: _____

Date: _____

Stamp of Business/Co-operative