



Application for Emergency Disaster Assistance

Provider information

| | | | | |
|----------------|-----------------------------|--------------|--------------------|-----|
| PROVIDER NAME | | | PROVIDER ID NUMBER | |
| STREET ADDRESS | CITY | COUNTY | STATE | ZIP |
| FAX NUMBER | NUMBER OF CLIENTS RELOCATED | LICENSE TYPE | | |

Attach invoices, receipts or other documentation to substantiate the claim. DHS must receive claims within 120 days of the emergency/disaster date. DHS may require additional information to complete the application process.

| List services provided that are eligible for reimbursement under federally approved disability waiver plans | Date | Cost incurred |
|---|-------------|---------------|
| | | |
| | | |
| | | |
| | | |
| Less reimbursements or pending insurance, FEMA, or other reimbursement claims | Leave blank | |
| Net application amount (claimed costs less offsets) | Leave blank | |

Narrative - use this space to briefly provide details for the claim amount.

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Person to contact for information

| | | |
|-----------------------|-----------------------|------------------------|
| PROVIDER CONTACT NAME | PROVIDER PHONE NUMBER | PROVIDER EMAIL ADDRESS |
| | | |

Provider signature

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| <p>I verify that the above submitted information is correct.</p> <hr/> <p>Authorized signature</p> |
| <p>Mail, fax or email applications to:</p> <p>DHS Response Center PO Box 64967 St. Paul, Minnesota 55164-0967 Telephone: 651-431-4300 (metro area) or 866-267-7655 (toll free) Fax: 651-431-7563</p> |