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Supporting Employment and on-the-job Training (SET)

APPLICATION PACKAGE FOR PERSONS WITH DISABILITIES

OVERVIEW

PART 1
Client Completes "Client Information"

PART 2
Client Completes "Employer Information"

If you have any questions, please contact a Program Development and Delivery Specialist at SET@gov.nu.ca

Note: If you are wishing to receive disability training supports, please contact your regions Career Development Office (CDO). Training Supports are funded under the Adult Learning and Training Support program for Persons with Disabilities.

Return to: Program Development and Delivery Specialist

Government of Nunavut
Career Development
Box 1000, STN. 1260
Iqaluit, NU X0A 0H0

SET@gov.nu.ca
Fax: (867) 975-5253

Supporting Employment and on-the-job Training (SET)

OVERVIEW

The Supporting Employment and on-the-job Training (SET) program is funded under the Workforce Development Agreement (WDA) to provide various supports to persons with disabilities and those facing barriers to employment by accommodating them within the workplace.

PROGRAM OBJECTIVES

That persons with disabilities or those who face persistent barriers to employment have equal opportunities available to them, particularly under the realm of employment.

ELIGIBLITY

Clients ages 16 years or older, employed or underemployed. Any clients who fit the description above may apply for this program.

EMPLOYER QUALIFICATIONS

Employers must be non-governmental organizations including organizations, private sector, Inuit Organizations, or Industry associations. **Clients must not be employed by the Government of Nunavut (GN) unless the client is employed under the SEEP program with the GN.**

ELIGIBLE EXPENSES

Eligible expenses are costs associated with accommodations required by the client, that meet the overall goal of finding and maintaining employment. Some examples of provided employment supports include:

Employment Supports:

- Helping prepare for work
- Help finding a job that suits your needs
- Help keeping a job
- Job coaching
- Software and Mobility Devices
- Transportation Assistance
- Assistive Devices
- Tools and equipment, you need for your job
- Special clothing

HOW TO APPLY

For more information on the SET program, please contact a Program Development and Delivery Specialist at SET@gov.nu.ca

- To receive **training supports**, please contact your Career Development Officer (CDO)
- To receive **employment supports**, please contact a Program Development and Delivery Specialist listed above.

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Supporting Employment and on-the-job Training (SET)

PART 1 - CLIENT INFORMATION

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

PERSONAL INFORMATION

Last Name	First Name	Middle Name(s)	Gender ☐ M ☐ F ☐ Other
Social Insurance Number	Date of Birth ____ (MM-DD-YYYY)	Nunavut Health Card Number	

Family Type: ☐ Children in Household ☐ No Children in Household Number of Dependents: ________

Marital Status: ☐ Single ☐ Married ☐ Common Law

Language(s) spoken: ☐ English ☐ French ☐ Inuktitut ☐ Inuinnaqtun ☐ Other: ______________________________

Language(s) written: ☐ English ☐ French ☐ Inuktitut ☐ Inuinnaqtun ☐ Other: ______________________________

Indigenous Identity: ☐ Inuit ☐ First Nation ☐ Métis ☐ NTI Card Number: ______________________________

Citizenship: ☐ Canadian ☐ Permanent Resident ☐ Other (Explain): ______________________________

Visible Minority: ☐ Yes ☐ No ☐ Prefer not to report

Immigrant: ☐ Yes ☐ No Immigration year: ______________________________

Do you identify as having a disability? ☐ Yes ☐ No ☐ Prefer not to report

(Examples include but not limited to: hearing, vision, or mobility impairment, learning disability, mental health difficulties, trauma history, motor skills or coordination difficulties, attention difficulties, problems with memory, sensory processing difficulties, chronic pain, other)

Type of Disability

☐ Agility ☐ Hearing ☐ Mental Health ☐ Visual ☐ Intellectual ☐ Developmental ☐ Learning ☐ Motor Skills ☐ Speaking

☐ Other (persistent barriers) ______________________________________

CONTACT INFORMATION

P.O. Box Number	Community	Territory/Province
Postal Code	Email	Telephone (Home) ( )
Telephone (Cell) ( )	Telephone (Work) ( )	Preferred method of communication: ☐ Email ☐ Mail ☐ Telephone

EDUCATION HISTORY

Highest level of education completed?	Place of Education
Name of Institution	End Date: _____ (MM-DD-YYYY)

List any training or educational programs you have completed.

	PROGRAM	INSTITUTION	LOCATION	START DATE MM - YYYY	GRADUATION DATE MM - YYYY
1					
2					
3					

EMPLOYMENT HISTORY

Current Employment Status

☐ Employed (Full-time/Permanent) ☐ Employed (Full-time/Temp/Casual) ☐ Unemployed
☐ Employed (Part-time/Temp/Casual) ☐ Employed (Part-time/Permanent) ☐ In training/Education
☐ Self-Employed

Current Employer (Business/Organization):	Employer Telephone Number: ( )
Employer Address:	

Recent Employment History: *Please list most recent employment first.*

COMPANY NAME	JOB TITLE	DUTIES	FULL-TIME/ PART-TIME	REASON FOR LEAVING	PERIOD OF EMPLOYMENT
			☐ FT Perm ☐ FT Temp ☐ PT Perm ☐ PT Temp		From (MM - YYYY) To (MM - YYYY)
			☐ FT Perm ☐ FT Temp ☐ PT Perm ☐ PT Temp		From (MM - YYYY) To (MM - YYYY)
			☐ FT Perm ☐ FT Temp ☐ PT Perm ☐ PT Temp		From (MM - YYYY) To (MM - YYYY)

Are you willing to move for employment? ☐ Yes ☐ No
Reasons:

Are you willing to move for training? ☐ Yes ☐ No
Reasons:

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

DRIVER'S LICENSE

Do you have a valid driver's license? ☐ Yes ☐ No

What type (class) of license is it?

☐ Class 1: Tractor Trailer Rigs
☐ Class 2: Buses exceeding 24 passengers
☐ Class 3: Single bodied motor vehicles exceeding 11,000 kg
☐ Class 4: Medium and small taxicab/ ambulance
☐ Class 5: Medium and small motor vehicles up to 11,000 kg
☐ Class 6: Motorcycle
☐ Class 7: Learner's permit

Do you have your airbrakes endorsement ? ☐ Yes ☐ No

NATURE OF DISABILITY

Please describe the nature of your disability and/or persistent barriers and the impact your disability has on your ability to find/maintain employment.

DESCRIPTION OF SUPPORTS REQUESTED

To the best of your ability, please identify what disability related support(s) you require and how they will increase the overall outcome in the workplace.

Requested Support:

How will the support(s) requested assist you in the training environment?

Have you received support from this program before? If so, when?

BUDGET

Please describe in the table below what support you are requesting, how long the support is needed, and the total cost of each support identified.
(If applicable) If you are unaware of the total cost of the support(s) requested, assistence can be provided to you.
Please provide a quote for support(s). (If applicable)

	Description of support requested	Durationt of support	Cost of support			
			Quantity	Cost per Unit (A)	Shipping Cost (B)	Total Cost (A+B)
1.						
2.						
3.						
4.						
5.						
Total Cost of Support (s) Requested						**$**

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

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CLIENT DECLARATION AND CONSENT TO RELEASE PERSONAL INFORMATION

I, _____, _____, hereby declare that:
PLEASE PRINT YOUR FULL NAME — SOCIAL INSURANCE NUMBER

1. The information contained in my application for assistance is complete, accurate and true, to the best of my knowledge.
2. I understand that false or misleading statements may result in legal action, criminal investigation, prosecution and my ineligibility to participate, including the termination of my benefits and repayment of any benefits I have already received.
3. I shall immediately notify the Department of Family Services should the circumstances of my eligibility or participation change.
4. I agree that if I have provided an email address, this will be the primary means of communication with me regarding my program.
5. I agree to refund any financial assistance to which I am not entitled.
6. I authorize and consent to the Government of Nunavut releasing, sharing or verifying of information about me and/or my spouse and/or my dependents to any agency, organization or other government department for the following purposes:
    a) Determining my initial and ongoing need, eligibility, or entitlement for programs or services, including financial assistance;
    b) Determining my status in participating, attending or making progress in programs and services; or
    c) Determining the results or outcomes from my participation or enrolment.

Dated this _____ Day of _____ 20 _____

_____
Client Signature

_____
Witness Signature

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

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PART 2 - EMPLOYER INFORMATION

Please fill out Section A. Employer Information

EMPLOYER INFORMATION

Business Legal Name	CRA Business Number	P.O. Box Number
Community	Territory/Province	Postal Code
Business Telephone ( )	Business Cell ( )	Email Address
Contact person Last Name	First Name	Position/Title
Business Type		

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

Signature of Employer

Date (MM-DD-YYYY)

Name of Employer (please print)

By signing this document, I hereby agree that the client indentified in Part 1 of this application is employed under the employer information stated in Part 2.

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