

Employability Assistance for People with Disabilities (EAPD)

Application for Services

EAPD provides a wide range of employment related supports, services and training primarily for unemployed adults who have a disability.

Basic Eligibility Criteria:

- Be 16 years of age or older
- Be willing to prepare for, obtain, and maintain employment
- Be living with a formally diagnosed **intellectual, psychiatric, and/or learning** disability

People living with other types of formally diagnosed disabilities can access services from the following agencies:

Physical Disabilities including the Deaf or Hard of Hearing	Vision-related Disability	Spinal Cord Injury
Manitoba Possible	Vision Loss Rehabilitation Manitoba	Spinal Cord Injury Manitoba Inc. (SCI Manitoba)
825 Sherbrook Street Winnipeg, MB R3A 1M5 Phone: 204-975-3010 Toll-free: 1-866-282-8041 TTY Deaf Access: 204-975-3012 TTY Toll-free: 1-800-225-9108 TTY Deaf Services: 204-975-3083 Fax: 204-975-3073	1080 Portage Avenue Winnipeg, MB R3G 3M3 Phone: 204-774-5421 Toll-free: 1-800-552-4893 Fax: 204-775-5090	825 Sherbrook Street Winnipeg, MB R3A 1M5 Phone: 204-786-4753 Toll-free: 1-800-720-4933 Fax: 204-786-1140

Please ensure that the following are included with the application:

- Current professional reports or assessments (within five years) from psychologists or psychiatrists
- Signed Privacy Notice and Consent form
- Social Insurance Number

If previously involved with the program and services were terminated or the individual withdrew from services, they must have addressed the issues that resulted in the initial closure in order to be considered for re-opening.

Completed applications may be sent to:

Employability Assistance for People with Disabilities
 Provincial Services Branch
 260–800 Portage Avenue
 Winnipeg, MB R3G 0N4
 Fax: 204-948-1008
EAPD@gov.mb.ca

Incomplete applications will be returned to the applicant or referral source for completion.

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PRIVACY NOTICE AND CONSENT FORM

Workforce Training and Employment

Workforce Training and Employment (WTE), within Government of Manitoba's Department of Economic Development, Investment and Trade works with employers, service providers, educational institutions, municipal, provincial and federal government departments, Manitoba Hydro, and agencies to provide a broad range of training and employment services to eligible participants ("services").

PRIVACY NOTICE

SECTION 1. WHY WTE NEEDS TO COLLECT AND USE YOUR INFORMATION ("PURPOSES")

WTE needs to collect and use your personal information and personal health information, if applicable, for the following purposes:

- to determine and verify if you are eligible to participate in WTE services,
- to assess your training and employment needs,
- to monitor and record your enrolment, participation and progress in WTE services,
- to administer and advertise WTE services,
- to identify and direct you to appropriate WTE services, and
- for research and planning, reporting, monitoring, evaluation and accountability purposes.

SECTION 2. OUR LEGAL AUTHORITY TO COLLECT YOUR INFORMATION

Your personal information and personal health information, if applicable, is necessary to provide you with WTE services, and to carry out the activities of WTE. Your personal information is collected under the authority of clause 36(1)(b) of *The Freedom of Information and Protection of Privacy Act* of Manitoba (FIPPA) and your personal health information, if applicable, is collected under the authority of subsection 13(1) of *The Personal Health Information Act* of Manitoba (PHIA). WTE limits the personal information and personal health information it collects about you to the minimum amount necessary for the purposes described in section 1.

Your personal information is protected by FIPPA and your personal health information is protected by PHIA. WTE cannot use or disclose your information for other purposes unless you consent or we are authorized to do so by FIPPA or PHIA.

SECTION 3. WHO DO I CONTACT IF I HAVE QUESTIONS

If you have any questions about the collection, use or disclosure of your personal information and personal health information, if applicable, please contact WTE at (204) 945-0575 or toll free at 1-866-332-5077.

CONSENTS

In entering your personal information and personal health information, if applicable, into WTE's case management system, or authorizing WTE, a service provider working for WTE, or another person to do so for you, you are consenting to WTE's collection, use and disclosure of your personal information and personal health information, if applicable, as outlined in this document.

SECTION 4. INFORMATION I AGREE TO PROVIDE TO WTE

I agree to provide WTE with the following personal information and personal health information, if applicable, about me. I understand that this information is necessary for me to participate in WTE services and to carry out the purposes described above in section 1:

- social insurance number,
- full name, telephone number, address, e-mail address,
- birth date, gender identity,
- education, job skills, experience and credentials,
- health conditions or disabilities that might affect my training or employment,
- details about my progress in WTE services,
- training or employment testing and reports,
- employment status: employed / self employed / not employed,
- employment plans, work experience, availability,
- Indigenous person,
- person with disabilities,
- member of a visible minority,
- immigrant/refugee,
- marital status, dependents
- follow-up information after completion of WTE services, including satisfaction with services received, employment status, whether WTE services prepared me for future employment, credentials or certifications achieved through WTE services, and my earnings.

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I agree to provide WTE with any changes to my personal information and personal health information in a timely manner.

SECTION 5. CONSENT TO WTE OBTAINING INFORMATION ABOUT ME FROM OTHER SOURCES

I consent to WTE collecting the following personal information and personal health information, if applicable, about me for the purposes described in section 1 from the persons and bodies listed below and consent to WTE providing such information about me as may be necessary to obtain the information WTE requires, and I consent to the persons and bodies disclosing the information to WTE: social insurance number

- full name, telephone number and address,
- e-mail address,
- birth date,
- gender identity,
- details about my progress in WTE services,
- employment testing and reports,
- medical reports related to employment,
- EI eligibility status, EI client status, EI claim information,
- language (English or French),
- provincial parental benefits,
- interventions
- indigenous person,
- person with disabilities,
- member of a visible minority,

Persons or bodies:

- any organization, agency or entity that has provided or is providing me with work experience, training or employment related services under contract with WTE,
- my schools and educational and training institutions,
- my physician _____,
- my other health care professionals: _____, and
- any Manitoba (MB) government department or agency, or federal government department or agency, that has provided or is providing me with services or assistance, including: Employment and Social Development Canada; Service Canada; MB Health & Seniors Care; MB Mental Health, Wellness & Recovery; MB Advanced Education, Skills and Immigration; MB Education; MB Families; MB Justice; MB Indigenous and Northern Relations; MB Municipal Relations; and MB Crown Services.

SECTION 6. CONSENT TO WTE DISCLOSING MY INFORMATION

I consent to WTE disclosing my personal information and personal health information, if applicable, to the following persons and bodies to the extent they need to know the information to carry out the purposes listed above in section 1:

- Employment and Social Development Canada; Service Canada; MB Health & Seniors Care; MB Mental Health, Wellness & Recovery; MB Advanced Education, Skills and Immigration; MB Education; MB Families; MB Justice; MB Indigenous and Northern Relations; MB Municipal Relations; and MB Crown Services,
- any organization, agency or entity that has provided or is providing me with work experience, training or employment related services, assistance or support under contract with WTE,
- service providers under contract with WTE to assess your training and employment needs and record your enrolment in WTE services, and
- consultants under contract with WTE to conduct research and evaluation of WTE services.

SECTION 7. HOW LONG DOES MY CONSENT LAST

I understand that the consents I have given will not be limited by time.

SECTION 8. CAN I WITHDRAW MY CONSENT

I understand that I may withdraw my consent at any time by contacting WTE in writing. However, I also understand that a withdrawal is not retroactive, and if I withdraw my consent, I will no longer be eligible to receive WTE services.

Client Signature

Date

Signature of Authorized Representative, Parent/Guardian if applicable

Date

Date: _____

Applicant Information:

Last Name	First Name	Middle Initial	Preferred Name
Home Phone Number	Cellular Phone Number	E-mail Address	
Preferred Communication Method <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Text		Correspondence Language <input type="checkbox"/> English <input type="checkbox"/> French	
Mailing Address	City/Town	Prov	Postal Code
Social Insurance Number	Date of Birth (yyyy/mm/dd)	EIA Case Number (if applicable)	

Disability/Health:

Please list all specific disabilities that may qualify the applicant for services. Psychologist or psychiatrist contact details are requested as it may be necessary to follow-up on their reports. **Diagnoses must be supported in writing and attached to this application.**

Diagnoses:

- _____
- _____
- _____
- _____

Psychologist Name:	Address	Phone
Psychiatrist Name:	Address	Phone
Other Specialist Name:	Address	Phone

Other medical concerns:

Education:

Are you currently in high school? Yes No *If yes, expected date of completion (mm/yyyy):* _____

Resource/Learning Support Teacher (if applicable)

Name: _____ *Phone:* _____

School: _____ *Email:* _____

Highest grade/level of education completed: _____ Date completed (yyyy): _____

Referral Source:

Name of person submitting this application if not the applicant: _____

Name of agency/school, if applicable: _____

Address (**including postal code**): _____

Phone Number: _____ Email: _____

Please describe the reasons for the referral and the types of services this individual may require to be successful in obtaining and maintaining competitive, paid employment:

Please identify any other programs, supports, or agencies involved:

	Contact Name	Contact Phone Number	Contact Email Address
Children's disABILITY Services (CDS)			
Community Living disABILITY Services (CLDS)			
Industry, Training and Employment Services (ITES)			
Employment and Income Assistance (EIA)			
Community Mental Health (CMH)			
Other: _____			

Employment Readiness (this section to be completed by the applicant)

Are you ready to pursue competitive, paid employment of at least 15 hours per week? Yes No

Please describe your employment goals:

Please describe the supports you may require in order to be successful in competitive, paid employment:

Please describe any challenges/barriers you have that would prevent you from participating in work or training:

Please describe areas of interest, hobbies, and community involvement:

Transportation:

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

Are you able to use public transportation independently? Yes No

What is your primary mode of transportation? Private vehicle Public transportation

Other, please describe: _____

Work Experience: Work experience may include paid employment, work placements (unpaid work) and volunteer activities.

No work experience to date

	1 (most recent)	2	3
Employer			
Job Title			
Wage/Salary			
Average Hours Worked per Week			
Start Date (yyyy/mm)			
End Date (if applicable) (yyyy/mm)			
Reason for Leaving	<input type="checkbox"/> laid off <input type="checkbox"/> fired <input type="checkbox"/> maternity/parental <input type="checkbox"/> relocated <input type="checkbox"/> quit <input type="checkbox"/> seasonal <input type="checkbox"/> medical <input type="checkbox"/> term ended <input type="checkbox"/> another job <input type="checkbox"/> other	<input type="checkbox"/> laid off <input type="checkbox"/> fired <input type="checkbox"/> maternity/parental <input type="checkbox"/> relocated <input type="checkbox"/> quit <input type="checkbox"/> seasonal <input type="checkbox"/> medical <input type="checkbox"/> term ended <input type="checkbox"/> another job <input type="checkbox"/> other	<input type="checkbox"/> laid off <input type="checkbox"/> fired <input type="checkbox"/> maternity/parental <input type="checkbox"/> relocated <input type="checkbox"/> quit <input type="checkbox"/> seasonal <input type="checkbox"/> medical <input type="checkbox"/> term ended <input type="checkbox"/> another job <input type="checkbox"/> other