



CLIENT INTAKE FORM

The department undertakes follow-up surveys to determine whether program support proves successful. In order to conduct such surveys, information is required. Some or all of the information may be shared with Services Canada to assist in evaluating the success of the programs.

Under the Privacy Act, the personal information on this form may be accessed by the participant. The information is kept on file at the Huronia Area Aboriginal Management Board Office.

Social Insurance Number		Name of Band		Band Number		Date of Birth (dd/mm/yy)	
Last Name			First Name			Middle Initial	
Area Code & Telephone Number		Mailing Address			Postal Code		
Physical Address/Current Address (if different from above)					Previous involvement with Huronia Yes: ____ No: ____ Date: _____		
Male <input type="checkbox"/>	Are You Living? On reserve <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/>		Valid Driver's License Yes <input type="checkbox"/> No <input type="checkbox"/>		Willing to Relocate Yes <input type="checkbox"/>	
Female <input type="checkbox"/>	Off Reserve <input type="checkbox"/>	Married/Equivalent <input type="checkbox"/>		Access to Vehicle Yes <input type="checkbox"/> No <input type="checkbox"/>		No <input type="checkbox"/>	
		Other <input type="checkbox"/>				Maybe <input type="checkbox"/>	
		Number of Dependents ____					
NEW/CURRENT EMPLOYMENT:							
Name of Employer:				Employer/Company Address:			
Contact Person:				Phone Number:			
Job title/Position:				Start Date:			
<i>Employment Verification by: (Office Use)</i>				<i>Person Contacted:</i>		<i>Date:</i>	
PREVIOUS EMPLOYMENT:							
Name of Employer:				Employer/Company Address:			
Contact Person:				Phone Number:			
Job Title:				Employed From:		To:	
Reason for Leaving:							
PREVIOUS EMPLOYMENT:							
Name of Employer:				Employer/Company Address:			
Contact Person:				Phone Number:			
Job Title:				Employed From:		To:	
Reason for Leaving:							
PHYSICAL CLASSIFICATION:							
Do you consider yourself a person with a disability? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, what is the nature of the disability?					
SOURCE OF INCOME:							
Employment Insurance <input type="checkbox"/> \$-----	Self Employed <input type="checkbox"/> \$-----	Canada Pension <input type="checkbox"/> \$-----					
Employed <input type="checkbox"/> \$-----	Ontario Works <input type="checkbox"/> \$-----	Social Assistance <input type="checkbox"/> \$-----					
Worker Compensation <input type="checkbox"/> \$-----	No Income <input type="checkbox"/> \$-----	Other <input type="checkbox"/> \$-----	Explain _____				
Partner/Spouse Income <input type="checkbox"/> \$-----							
Were you in receipt of Employment Insurance Benefits in the last 3 years? Yes <input type="checkbox"/> No <input type="checkbox"/>				Were you in receipt of Employment Insurance Benefits in the last 5 years if on maternity or parental leave? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>Income Verification by: (Office Use)</i>		<i>Ontario Works Yes <input type="checkbox"/> No <input type="checkbox"/></i>		<i>Person Contacted:</i>		<i>Date:</i>	
EDUCATION BACKGROUND:							
Are you currently enrolled in some level of education? Yes <input type="checkbox"/> No <input type="checkbox"/>		Highest grade attained?			Did you receive: GED <input type="checkbox"/>		
					High School Diploma <input type="checkbox"/>		
Did you attend College or University? Yes <input type="checkbox"/> No <input type="checkbox"/>		Program Taken:			Did you Receive: Diploma <input type="checkbox"/>		
					Certificate <input type="checkbox"/>		
Type of Employment Assistance Required: Interview <input type="checkbox"/> Travel Assistance <input type="checkbox"/> Relocation <input type="checkbox"/> Start Up <input type="checkbox"/> Other <input type="checkbox"/> (Explain)							
Signature of Applicant:				Date:			



APPLICATION FOR FINANCIAL ASSISTANCE & TRAINING REQUEST

NOTE: All applicants must fill out and sign the “Release of Information” section on this page. Only those applying for financial assistance for a training program have to fill the section pertaining to Institutional and Training and other sections marked with an ‘*’ and submit a training research package.

RELEASE OF INFORMATION	
I, _____ of _____	_____
Name	Address
hereby consent to the collection, disclosure and use of my personal information, that is: <ol style="list-style-type: none"> 1. The application for financial assistance and training request; 2. My social insurance number for E.I eligibility; 3. Information for determining and verifying program eligibility; 	
I further consent to the exchange of such information by: <ul style="list-style-type: none"> <input type="checkbox"/> Services Canada <input type="checkbox"/> Funding agencies such as First Nations, LDM’s, & AHRDA’s <input type="checkbox"/> Training Deliverer’s (schools, institutions, etc.) <input type="checkbox"/> Ontario Works and Ontario Disability support Programs; <input type="checkbox"/> Affiliated employment & training units (O-GI) 	
I understand that this information may be shared with Canada and that I will have access to any or all of the information held by Canada.	
I have read this document and fully understand the above notice. I consent to the collection, disclosure and use of my personal information as described therein.	
_____	_____
Participants Name:	Witness Name:
_____	_____
Participants Signature :	Witness Signature:
_____	_____
Date:	Date:

TRAINING REQUEST INFORMATION		
Name of Institution/Agency:	Contact Person:	Phone/Fax #:
Type of Training:	Start Date:	End Date:
Tuition/Registration:	Equipment/Supplies	Training Allowance
Employment Startup:	Relocation:	Mileage (Distance)
Child Care Costs:	Accommodations:	Total Funding Requested:

FOR OFFICE USE ONLY	
Funding Approved:	
Employment Assistance \$ _____	Travel Assistance \$ _____
Relocation Assistance \$ _____	Other Assistance \$ _____
Total Assistance \$ _____	Funding: <input type="checkbox"/> E.I <input type="checkbox"/> CRF
Approved By: _____	Date: _____