Reset

Contract : _____

Department of Post-Secondary Education, Training and Labour

Training and Employment Support Services
Application Form

Client Information:

First Name: **Middle Name:** **Last Name:**

Address: **City:**

Province: **Postal Code:** **Email:**

Telephone: **Alternate Telephone:** **TTY/Text:**

Language of Service: ☐ English ☐ French **Gender:** ☐ Male ☐ Female

Social Insurance Number: **Date of Birth:** yyyy/mm/dd

Highest level of education completed:

Target Groups:

Primary Disability:

☐ Hearing ☐ Intellectual ☐ Learning ☐ Mental Health

☐ Mobility ☐ Speech ☐ Vision ☐ Other (specify):

Other:

☐ Aboriginal ☐ EI Active ☐ EI Reachback ☐ Social Assistance Recipient

Referral Agent Information:

Referral Agency:

Referral Agent Name: **Telephone:**

Email: **Fax:**

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Employment Action Plan Information:

1- Employment action plan goal is:

- ☐ Academic Upgrading, indicate level: _____
- ☐ Post-Secondary Education, indicate the field of study: _____
- ☐ Employment, indicate field of employment: _____

2- Does the employment action plan contain clear and attainable goals? ☐ Yes ☐ No

3- Have the impacts of the disability been considered in the employment action plan? ☐ Yes ☐ No

4- Has the client applied for or is receiving funding from any of the following sources *(check all that apply)*: ☐ Yes ☐ No

- ☐ Canada Student Grant for Services and Equipment for Students with Permanent Disabilities. (CSG PDSE);
- ☐ CPP-Disability;
- ☐ WorkSafeNB;
- ☐ Disability Insurance;
- ☐ Insurance Settlement;
- ☐ Private Insurance Companies;
- ☐ Training and Skills Development Program (TSD);
- ☐ Disability Support Program (Social Development);
- ☐ Vehicle Retrofit Program (Transportation and Infratructure);
- ☐ Other (specify): _____

***If yes**, indicate the amount of contribution:* _____

5- For post-secondary education, is the institution:

- o recognized by the Canada Student Loans Program; **or**
- o recognized by the Provincial Occupational Training Act (POTA); **or**
- o recognized by the Canadian Association for Co-Operative Education (CAFCE); **or** ☐ Yes ☐ No
- o on the List of Recognized training providers (TSD); **or**
- o approved by Central Office.

Name of Institution: _____

6- For employment, is the client currently employed? ☐ Yes ☐ No

If yes: - has he/she been working for the current employer for less than 30 weeks? ☐ Yes ☐ No

- will the employer contribute to the cost of the requested support? ☐ Yes ☐ No

If yes: - indicate employer's contribution: _____

- indicate employer's name: _____

7- Provide details of the employment action plan including research done on labour market opportunities and requirements:

_____

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TESS Support Requested ***(If the request for support includes Assistive Technology (AT), please list all the AT already owned by the individual in the RATIONALE box below. Ex.: computer, laptop, IPad, etc.):***

RATIONALE ***(Describe the TESS support being requested, the impacts of the disability in the employment action plan and how the support will help the client attain his/her employment action plan goals)*****:**

_____

NOTE: For all items, support and services requested, the following is **required**:

- o A minimum of two quotes (if less than two, please include the reason in the rationale);
- o The quotes must be included in the application package;
- o Only enter the recommended quotes in the following tables.

ITEMS REQUESTED:

Recommended Quotes ***(Assistive technology, Books, etc…)***			**OFFICE ONLY**	
Items	Suppliers	Quotes	Approved Amount	Denied
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
	Total Cost			

SUPPORT and SERVICES REQUESTED:

Recommended Quotes ***(Tutoring, Interpreter, etc…)***							**OFFICE ONLY**	
Support and Services	Start date YYYY-MM-DD *Select date from drop down calandar*	End date YYYY-MM-DD *Select date from drop down calandar*	Number of weeks	Number of hours per week	Rate per hour	Quotes	Approved Amount	Denied
								☐
								☐
								☐
								☐
								☐
								☐
					Total Cost			

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Client Consent:

I certify that the information contained in this form is correct and accurate. I also authorize the Department of Post-Secondary Education, Training and Labour, its agents, and service providers to collect, use, and disclose the information on this form for the purpose of:

- providing the approved support; and
- contacting me to collect information concerning my employment and/or training status and for the monitoring and evaluation of Training and Employment Support Services for research and improvement purposes.

I also certify that I am a New Brunswick resident as per the following definition: A person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in New Brunswick, but does not include:

- students from another province or on student visas; and
- tourists and visitors to the province; and
- transients; and
- inmates of federal penitentiaries.

Printed Name of Client	Signature of Client	Date
Printed Name of Parent, Guardian or Trustee *(for client under the age of 19)*	**Signature of Parent, Guardian or Trustee** *(for client under the age of 19)*	**Date**

Printed Name of Referral Agent	Signature of Referral Agent	Date

OFFICE USE ONLY

Approval Status: Approved ☐ Denied ☐ Recommended to RD ☐

Printed Name of TESS Coordinator	Signature of TESS Coordinator	Date

Approval Status: Approved ☐ Denied ☐

Printed Name of Regional Director	Signature of Regional Director	Date

Rationale:

Funded by the Government of Canada and the Province of New Brunswick through the Canada-New Brunswick Labour Market Agreements