



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:

Employment Action Plan Information:

1- Employment action plan goal is: <input type="checkbox"/> Academic Upgrading, indicate level: _____ <input type="checkbox"/> Post-Secondary Education, indicate the field of study: _____ <input type="checkbox"/> Employment, indicate field of employment: _____	
2- Does the employment action plan contain clear and attainable goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3- Have the impacts of the disability been considered in the employment action plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4- Has the client applied for or is receiving funding from any of the following sources (<i>check all that apply</i>): <input type="checkbox"/> Canada Student Grant for Services and Equipment for Students with Permanent Disabilities. (CSG PDSE); <input type="checkbox"/> CPP-Disability; <input type="checkbox"/> WorkSafeNB; <input type="checkbox"/> Disability Insurance; <input type="checkbox"/> Insurance Settlement; <input type="checkbox"/> Private Insurance Companies; <input type="checkbox"/> Training and Skills Development Program (TSD); <input type="checkbox"/> Disability Support Program (Social Development); <input type="checkbox"/> Vehicle Retrofit Program (Transportation and Infrastructure); <input type="checkbox"/> Other (specify): _____ <i>If yes, indicate the amount of contribution: _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5- For post-secondary education, is the institution: <input type="radio"/> recognized by the Canada Student Loans Program; or <input type="radio"/> recognized by the Provincial Occupational Training Act (POTA); or <input type="radio"/> recognized by the Canadian Association for Co-Operative Education (CAFCE); or <input type="radio"/> on the List of Recognized training providers (TSD); or <input type="radio"/> approved by Central Office. <i>Name of Institution: _____</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6- For employment, is the client currently employed? If yes: - has he/she been working for the current employer for less than 30 weeks? - will the employer contribute to the cost of the requested support? If yes: - indicate employer's contribution: _____ - indicate employer's name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
7- Provide details of the employment action plan including research done on labour market opportunities and requirements: _____	

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
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
Total Cost		\$0.00		

SUPPORT and SERVICES REQUESTED:

Recommended Quotes (Tutoring, Interpreter, etc...)						OFFICE ONLY		
Support and Services	Start date YYYY-MM-DD <small>Select date from drop down calendar</small>	End date YYYY-MM-DD <small>Select date from drop down calendar</small>	Number of weeks	Number of hours per week	Rate per hour	Quotes	Approved Amount	Denied
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
Total Cost						\$0.00		

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:

- o providing the approved support; and
- o 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:

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

Printed Name of Client	Signature of Client	Date
Printed Name of Parent, Guardian or Trustee <i>(for client under the age of 19)</i>	Signature of Parent, Guardian or Trustee <i>(for client under the age of 19)</i>	Date

Printed Name of Referral Agent	Signature of Referral Agent	Date
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OFFICE USE ONLY		
Approval Status:	Approved <input type="checkbox"/>	Denied <input type="checkbox"/> Recommended to RD <input type="checkbox"/>
Printed Name of TESS Coordinator	Signature of TESS Coordinator	Date
Approval Status:	Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
Printed Name of Regional Director	Signature of Regional Director	Date
Rationale:		