SHOONIYAA WA-BIITONG TRAINING AND EMPLOYMENT CENTRE FOR THE TREATY #3 AREA
P.O. BOX 2909, KENORA, ONTARIO, P9N 3X8, TEL. (807) 468-2030, FAX (807) 468-1813, TOLL-FREE (800) 545-5113

APPLICATION FOR FINANCIAL ASSISTANCE

INDIVIDUAL INITIATIVES

Type of Assistance Required: ☐ **Purchase of Training** ☐ **Travel Assistance**
☐ **Special Employment Supports** ☐ **Other**

Name of Applicant:		**SIN #:**
Date of Birth: Day	**Month**	**Year**
Mailing Address:		**City/Town**
Province:	**Postal Code:**	**Telephone:**

Sex: Male: ☐ **Female:** ☐ **Disabled (Voluntary) :** ☐

Residence: On Reserve ☐ **Off Reserve** ☐

First Nation Affiliate _____ **Band No.** _____

State Province if First Nation is outside Ontario _____

Have you received funding through SHOONIYAA WA-BIITONG, HRDC or other previous to this? If YES, state purpose and when.

_____

Have you requested funding for this program from any other agency, and if so, indicate reasons for funding denied.

_____

_____

CURRENT STATUS ☐ **Employed** ☐ **Unemployed**

Estimated Monthly Income presently receiving:

- **WSIB** **$**_____ **ODSP** **$** _____
- **Employment Insurance** **$**_____ **Employment Income** **$** _____
- **Social Assistance** **$**_____
- **Other** **$**_____ **Explain** _____

Dependent Care:

1. Will you be requiring financial assistance to cover child/dependent care while you are on the program?
2. Will you be or do you anticipate receiving a dependent/child care subsidy from the local municipality, approved corporation or Aboriginal Band? ☐ Yes ☐ No
3. If NO, do you need dependent/child care assistance? ☐ Yes ☐ No
4. If YES, please provide the name(s) and details for each dependent/child below:

	Name of Dependent	Date of Birth d/m/y	Special Care	Hours of Dependent Care Required
1				
2				
3				
4				
5				

5. Name and Address of Care Giver:_____

_____

Does this individual currently reside with you? Yes ☐ No ☐

SECTION A – TRAINING INFORMATION

(Please complete this section if you are applying for financial assistance to participate in a course)

Duration of Activity: From / / To / /

Attendance: ☐**Full Time** ☐**Part-Time** **Number of Hours Per Week:** _____

Course Title:

Location of Activity:_____ **# of kms from residence to training site:**_____

Name of Training Delivery Agency:_____
(Attach training plan and costs)

Institutional Acceptance: Have you received an acceptance letter? Yes ☐ **Please attach**
No ☐

FINANCIAL REQUIREMENTS

Course Costs and Materials

- **Course Cost/Tuition** _____
- **Books and Supplies** _____
- **Other Materials Required** _____

TOTAL COURSE COSTS AND MATERIALS **$**_____

Income Support Requirements

- **Allowance** _____
- **Dependent Care/Day Care (if applicable)** _____
- **Travel – Commuting** _____
- **Other** _____ **$**_____

If Course is away from Home, what are your expected weekly expenses **$**_____
Weekly expenses $ _____ x # of weeks away from home _____weeks

Include costs related to a Disability barrier **$** _____

TOTAL COSTS TO ATTEND THE TRAINING COURSE **$**_____

Once you have completed Section A please skip to Section D – Thank You!!

SECTION B – TRAVEL ASSISTANCE

(Please complete this section if you are applying for one time travel assistance)

Reason for request: _____

Letter of confirmation of employment from employer attached: ☐**Yes** ☐**No**

Quotes of Travel Costs: **Air** _____ **Public** _____
Private _____ **Other** _____

Have you approached other sources of funding? ☐**Yes (If yes, attach letters of refusal)**
☐**No**

SECTION C – SPECIAL EMPLOYMENT SUPPORTS

(Please complete this section if you are applying for Special Employment Supports)

Reason for request: _____

Letter of confirmation of employment from employer attached: ☐**Yes** ☐**No**

Quotes: (Two quotes required) _____
_____

Have you approached other sources to cover the costs?
☐**Yes (If yes, attach letters of rejection)** ☐**No**

SECTION D – EXPECTATIONS/EMPLOYMENT GOALS

In summary, state what your expectations and employment goals are once the intervention is completed.

_____

_____

_____

_____

_____

SECTION E – SIGNATURE

I certify that the above information is accurate and true to the best of my knowledge. If funding is approved, I will adhere to SHOONIYAA WA-BIITONG program policy guidelines. Failure to do so or knowingly providing false information will result in funding (if approved) being revoked.

Client Name:_____ **Client Signature:**_____

Date:_____

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Official Use Only:

Insert File Number:

Date Received:_____

Signature_____

Revised 02/03/06 – Effective 01/04/06