

## 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:

<b>Physical Disabilities including the Deaf or Hard of Hearing</b>	<b>Vision-related Disability</b>	<b>Spinal Cord Injury</b>
Society for Manitobans with Disabilities (SMD)	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 (within five years) professional reports or assessments 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  
Skills and Employment Partnerships Branch  
260–800 Portage Avenue  
Winnipeg, MB R3G 0N4  
Fax: 204-948-1008  
[EAPD@gov.mb.ca](mailto: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

## SKILLS AND EMPLOYMENT PARTNERSHIPS

### EMPLOYABILITY ASSISTANCE FOR PEOPLE WITH DISABILITIES

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Skills and Employment Partnerships (SEP), within the Manitoba government’s Department of Education and Training works with employers, service providers, educational institutions, municipal, provincial and federal government departments and Manitoba Hydro, and agencies to provide a broad range of training and employment services to eligible participants (“services”).

#### PRIVACY NOTICE

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

SEP 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 SEP services,
- to assess your training and employment needs,
- to monitor and record your enrolment, participation and progress in SEP services,
- to administer and enforce SEP 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 SEP services, and to carry out the activities of SEP. 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). SEP 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. SEP 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 SEP 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 SEP’s case management system, or authorizing SEP or another person to do so for you, you are consenting to SEP’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 SEP

I agree to provide SEP 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 SEP services and to carry out the purposes described above in section 1:

- full name, telephone number and address,
- e-mail address and fax number (if any),
- birth date,
- gender,
- education, job skills, experience and credentials,
- health conditions or disabilities that might affect my training or employment,
- details about my progress in SEP services,
- training or employment testing and reports,
- employment status: employed / self employed / not employed,
- employment plans, work experience,
- availability,
- follow-up information after completion of SEP services, including satisfaction with services received, employment status, whether SEP services prepared me for future employment, credentials or certifications achieved through SEP services, and my earnings, and
- social insurance number (S.I.N)
- I also agree to provide SEP with any changes to my personal information and personal health information, if applicable, in a timely manner.

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

I consent to SEP 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 SEP providing such information about me as may be necessary to obtain the information SEP requires, and I consent to the persons and bodies disclosing the information to SEP:

- details about my progress in SEP services,
- employment testing and reports,
- employment plans,
- medical reports related to employment,
- work experience, availability
- EI eligibility status,
- EI claim information,
- language (French or English),
- provincial parental benefits,
- education level, interventions,

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 SEP,
- my schools and educational and training institutions,
- my physician, healthcare 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, and Active Living; MB Families; MB Growth, Enterprise and Trade; MB Justice; MB Indigenous and Northern Relations; MB Municipal Relations; and MB Crown Services.

**SECTION 6. CONSENT TO SEP DISCLOSING MY INFORMATION**

I consent to SEP 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 Education and Training; MB Health, Seniors, and Active Living; MB Families; MB Growth, Enterprise and Trade; MB Justice; MB Indigenous and Northern Relations; MB Municipal Relations; and 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 SEP, and
- consultants under contract with SEP to conduct research and evaluation of SEP 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 SEP 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 SEP services.

**ADDITIONAL INFORMATION**

SEP wishes to obtain the following self declaration information from you for research and planning, reporting, monitoring, evaluation and accountability purposes.

*Providing this self declaration information is optional. Not providing it will not affect your eligibility for SEP services, but it may be to your benefit to provide this information.*

1. **Indigenous Person** – North American Indigenous ancestry (Métis/Inuit/Status Indian/Non-Status Indian)
2. **Member of a Visible Minority** – other than an Indigenous person. Because of race or colour I am considered a visible minority.
3. **Immigrant/Refugee** – Immigrant – I am a person who has settled permanently in Canada from another country. An immigrant includes those who have obtained a Canadian passport or who have been granted Citizenship or who have obtained Permanent Resident status. Refugee – I am a person who was forced to flee from another country and settled in Canada.
4. **Marital Status** – I am either: 1. Single or 2. Married with a spouse or living with a common-law partner.
5. **Dependents** – Individual(s) who live in the same household as me and for whom I have caregiving responsibilities. The dependent is a child(ren) (by birth, marriage, adoption or be a foster child) or an adult(s) dependent (e.g. an adult offspring with a disability).

\_\_\_\_\_  
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	
Permanent 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 in a report 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 (the section to be completed by the applicant)**

**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 Readiness:**

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:

**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 (yyyy/mm)			
Reason for Leaving (choose one)	<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