APPLICATION FOR FINANCIAL ASSISTANCE
INDIVIDUAL INITIATIVES

Section A – Employment Goals – State what your employment goals are and your expectations once the intervention is completed

_____
_____
_____
_____
_____

Have you requested funding for this program from any other agency? ☐ Yes ☐ No

If yes, please provide name of agency and the outcome:

_____

Are you eligible to apply for Employment Insurance or will you be applying within the next month? ☐ Yes ☐ No

Have you worked 490 hours or more in the last 12 months? ☐ Yes ☐ No

Section B – Training Information *(Complete this section if you are applying for financial assistance to participate in a course)*

Attached Acceptance Letter ➔	☐ Yes ☐ No ☐ Not Applicable	**Duration of Activity ➔**	___/___/___ *to* ___/___/___ MM DD YY MM DD YY
Name of Training Delivery Agency: (Attach training plan and costs)		Attendance: ☐ Full-time ☐ Part-time	Number of Days per week: / Number of Hours per week:
Course Title:	Location of Activity:		Number of kms from residence to training site:

Financial Requirements ➔	Course Cost: $_____	Books/Materials: $_____	**Total Course Costs and Materials:** $_____
Income Supports ➔ **Check all required:** ☐ Allowance ☐ Dependent Care ☐ Travel ☐ Other	If the course is away from home, what are your expected weekly expenses? $_____	Weekly expenses $_____ x # of weeks away from home (_____ weeks) = $_____	
	Include costs related to disability barrier: $_____	**Total Income Supports**: $_____	

TOTAL COST TO ATTEND TRAINING COURSE: $_____

Dependent Care:

1. Will you be requiring financial assistance to cover child/dependent care while you are on the program? ☐ Yes ☐ No
2. Will you be receiving financial assistance from another source? ☐ Yes ☐ No
3. Does the caregiver currently reside with you? ☐ Yes ☐ No

If NO, please provide the name(s) and details for each dependent/child below:

	Name of Dependent	Age	Special Care	Hours of Care Required
1				
2				
3				
4				
5				

Name and Address of Caregiver:

Section C – Travel Assistance *(Complete this section if you are applying for one time only travel assistance)*			
Attached Letter of Confirmation of Employment from Employer ➔	☐ Yes ☐ No	**Date of Travel ➔**	____/____/____ *to* ____/____/____ MM DD YY MM DD YY
Reason for request:		Quotes for Travel:	Air: _____ Private: _____ Public: _____ Other:_____

Section D – Special Employment Supports *(Complete this section if you are applying for Special Employment Supports)*		
Attached Letter of Confirmation of Employment from Employer ➔	☐ Yes ☐ No	
Reason for request:	Quotes: (Two Required)	_____ _____

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.

Participant's Signature:	Date:

Shooniyaa Wa-Biitong is committed to respecting your privacy and protecting your personal information. This document and the information in it are provided in confidence, for the sole purpose of Shooniyaa Wa-Biitong, and may not be disclosed to any third party or used for any other purpose without the express written purpose of the participant.

Please provide additional supporting documentation as required to support your application.

Please allow up to 20 business days from the date we receive your application for a final decision.

Official Use Only:

Client ID Number:	**Program Officer:**	**Date Received:**
__/__/__/__/__/__/__/__/		