

Keewatin First Nations Employment and Training (KFNET) Inc.
Contact IV Information Form

To be completed by Local Employment and Training Services Coordinators: (Please print clearly)
****NOTE** This form only pertains to clients supported from your local Employment and Training budget.**

Client Information:

S.I.N.	Surname:		First Name & Middle Initials:	
Birth Date: <small>Day Month Year</small>	Phone No. 2 0 4		Other for Messages 2 0 4	
Address:		Prov.	Postal Code:	Highest Grade Completed: Other: (Explain)
Project or Contract Number: <input type="checkbox"/> CRF- G533672 <input type="checkbox"/> E.I.- G533714		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Must be funded by Local Board - HRDC Client? <input type="checkbox"/> Yes <input type="checkbox"/> No
First Nation Origin:		Residing: <input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve		Person With Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Explain:

Client Action Plan / Intervention

- Dimension: (Check One)

<input checked="" type="checkbox"/> A Career Decision-Making	<input type="checkbox"/> Assistance with helping client make a career choice
<input type="checkbox"/> B Skills Enhancement	<input type="checkbox"/> Training to improve client's skill level
<input type="checkbox"/> C Job Search	<input type="checkbox"/> Assisting client with their search for employment
<input type="checkbox"/> D Employment Maintenance	<input type="checkbox"/> Re-training a client who is already employed to improve their skill level

Service Provider: (Training Institution Attending)			Name of Course:		
Start Date: <small>Day Month Year</small>	End Date: <small>Day Month Year</small>	BF Date: <small>Day Month Year</small>	← 12 Weeks After End Date		
<ul style="list-style-type: none"> Complete the information below 12 weeks after client's training has ended. 					
Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, give reason for incomplection:					

Case File Closure

- Complete the information below 12 weeks after client's training has ended.
- Client's Status at Action Plan Closure: (Check One)

<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Returned to School
Date: <small>Day Month Year</small>	Completed By: (Print Name)		Position:

Target Group

- Client Group You Are Targeting: (Check One)

<input type="checkbox"/> Employment and Training	<input type="checkbox"/> Youth (15-30 Years)	<input type="checkbox"/> Persons With Disabilities	<input type="checkbox"/> Child Day Care
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The participant and HRDC may access the personal information collected on this form. The appropriate Local Board of which the participant is the member of the First Nation holds the information. Paper copy or disk down-loaded containing this information **must** be forwarded to KFNET Inc. for results and accountability reasons under the AHRDS agreement.

**OPASKWAYAK CREE NATION
EMPLOYMENT AND TRAINING
PARTICIPANT INFORMATION FORM**

OFFICIAL USE ONLY	FILE NAME OR NUMBER:	RESPONSIBILITY CENTRE CANADA (RCC) CODE: 4186	SOURCES OF FUNDS: <input type="checkbox"/> E. I. <input type="checkbox"/> CRF
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1. SOCIAL INSURANCE NUMBER :		2. TREATY NUMBER:	
3. SURNAME/FAMILY NAME:		4. GIVEN NAME AND INITIALS:	
4. TELEPHONE NUMBER: 2 0 4		5. OTHER NO. FOR MESSAGES 2 0 4	
6. HOME OR MAILING ADDRESS:		City, Town, or First Nation	
PROVINCE	POSTAL CODE	7. NAME OF FIRST NATIONS ORIGIN	8. LAMB CONTACT NAME
			LAMB PHONE NUMBER 2 0 4
9. MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> WIDOWED		10. EDUCATION: <input type="checkbox"/> COMPLETED <input type="checkbox"/> INCOMPLETE <input type="checkbox"/> OTHER (Specify)	
		11. NO. OF DEPENDANTS:	
12. LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> OTHER (Specify)		14. GENDER / SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
13. DATE OF BIRTH: Year Day Month		15. PERSON WITH A DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
16. INTERVENTION TITLE: ABORIGINAL		18. INTERVENTION END DATE:	
17. START DATE Day Month Year		19. OUTCOME: <input type="checkbox"/> COMPLETED <input type="checkbox"/> ABANDONED / INCOMPLETE	
20. RESULT: <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETURNED TO SCHOOL <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> NOT EMPLOYED		21. DATE OF INTERVENTION RESULT ACHIEVED:	
		22. OTHER TRAINING TAKEN: - FR TO	

DURING THE LAST 12 MONTHS, IF YOU WERE EMPLOYED, PLEASE ANSWER THE FOLLOWING QUESTIONS.

(Provide at least two words to describe it)

21. OCCUPATION OF YOUR CURRENT OR LAST JOB:	
22. YOUR NORMAL WEEKLY HOURS OF WORK: /HOURS PER WEEK	23. NORMAL WEEKLY GROSS WAGES: \$ /PER WEEK

THE FOLLOWING QUESTIONS RELATE TO YOUR PARTICIPATION AND SOURCE OF FUNDING UNDER MANITOBA FIRST NATIONS TRAINING AND EMPLOYMENT.

24. YOUR START DATE ON THIS TRAINING PROGRAM: Year Day Month		25. YOUR END DATE ON THIS TRAINING: Year Day Month	
(Provide at least two words to describe it)			
26. TITLE OF THE SKILL OR OCCUPATION YOU ARE BEING TRAINED FOR?			
27. IMMEDIATELY PRIOR TO YOUR PARTICIPATION, WERE YOU: =>		(i) IN RECEIPT OF PROVINCIAL SOCIAL ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		(ii) IN RECEIPT OF CITY / MUNICIPAL SOCIAL ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		(iii) IN RECEIPT OF FIRST NATIONS SOCIAL ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

28. ACCOUNT FOR YOUR STATUS DURING THE LAST 12 MONTHS BY INDICATING THE NUMBER OF MONTHS EMPLOYED IN EACH ACTIVITY LISTED: FT PT SELF-EMP UNEMP SCHOOL TRNG HOMEMKR OTHER = 12 MOS.									
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29. IN RECEIPT OR ELIGIBLE FOR EI BENEFITS WHEN YOU STARTED THIS PROGRAM: <input type="checkbox"/> YES <input type="checkbox"/> NO				30. IF YES, GROSS WEEKLY RATE: \$			
31. NUMBER OF WEEKS ENTITLED:		32. BENEFIT PERIOD STARTED:		33. BENEFIT PERIOD ENDING:		34. PARTICIPANT ELIGIBLE FOR LAMB SPONSORSHIP TRAINING? <input type="checkbox"/> YES <input type="checkbox"/> NO	

35. HAVE YOU BEEN ON E. I. IN THE LAST 3 YEARS OR WAS ON MATERNITY LEAVE OR ADOPTING IN THE LAST 5 YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO		36. MEMBER OF OTHER FIRST NATIONS OUTSIDE MANITOBA? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES: PROV./TERR.)	
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THE PERSONAL INFORMATION COLLECTED ON THIS FORM MAY BE ACCESSED BY THE PARTICIPANT AND HRDC. THE INFORMATION IS HELD BY THE APPROPRIATE BOARD OF WHICH THE PARTICIPANT IS THE MEMBER OF THE FIRST NATIONS OF MANITOBA.

Signature of Participant	Print Name	Date

OFFICIAL USE ONLY	ACTION PLAN DIMENSION/TYPE OF ASSISTANCE (Check One)
<input type="checkbox"/> (A) Career Decision Making: (Assisting client with career a choice)	<input type="checkbox"/> (C) Job Search: (Assisting client in search for employment)
<input type="checkbox"/> (B) Skills Enhancement: (Training an unemployed client to gain or improve skill level)	<input type="checkbox"/> (D) Employment Maintenance: (Re-training an employed client to improve present skills)

(Participant Information Form)

INSURED PARTICIPANT FINANCIAL ASSISTANCE AND REFERRAL FORM - (E.I. PART 1 BENEFITS)

The purposes of this form are:

1. To document your request for financial assistance from Human Resources Development Canada (HRDC) or designate authority under the Employment Benefit referred to below to enable you to participate in the course or program of instruction or training or other employment activity ("Employment Activity") described in your Return to Work Action Plan ("Action Plan");
2. If, at the start of your participation in the employment activity you are a claimant and are qualified to receive Insurance Benefits ("E.I. benefits") under Part 1 of the Employment Insurance Act ("E.I. Act"), to document your referral to the employment activity by the Commission (or by an authority designated by the Commission) for the purpose of entitling you to receive E.I. benefits for each week during your E.I. benefit period that you are participating in the employment activity; and
3. To document your agreement to be referred to the employment activity.

TO BE USED ONLY FOR FINANCIAL ASSISTANCE AND REFERRAL TO TRAINING OR SECTION 25 FOR CLIENTS ON HRIF ELIGIBILITY (E.I. PART 1 BENEFITS).

S. I. N.		PROJECT - CEC CODE INFORMATION			<i>Day Month Year</i>
		TYPE: T	TYPE:	START-WEEK/DAY:	
END-WEEK/DAY:		PROJECT-CEC (RCC) 4186		<input type="checkbox"/> REFERRED TO TRAINING	<input type="checkbox"/> SECTION 25
RATE: 000		TRAINING ID: 35	SECTION 25 ID:	AGREEMENT NO.: G440597	

SURNAME		GIVEN NAME		INITIALS
ORDINARY RESIDENCE ADDRESS			COURSE NAME	
<i>ADDRESS:</i> _____			<i>CITY:</i> _____	
<i>PROV.:</i>	<i>POSTAL CODE:</i>	<i>PHONE NO.:</i>		
TEMPORARY TRAINING ADDRESS			INSTITUTION	
<i>ADDRESS:</i> _____			<i>CITY:</i> _____	
<i>PROV.:</i>	<i>POSTAL CODE:</i>	<i>PHONE NO.:</i>		

CERTIFICATION

I certify that:

- a) The information I have provided to the Commission in support of my request for financial assistance under the E.I. Act to enable me to carry out employment activity described in my Action Plan is true, accurate and complete in every respect;
- b) I will inform the sponsor of any material change in financial circumstances affecting my need for financial assistance and in the information I have provided with respect to my financial needs;
- c) I understand that a monetary penalty may be imposed upon me under the E.I. Act for knowingly making false or misleading representations or declarations in relation to my request for financial assistance;
- d) I have agreed to be referred to the employment activity by the Commission or, if applicable, by an authority designated by the Commission; I declare that I am eligible to receive E.I. benefits, I hereby agree to be referred under Section 25 of the E.I. Act to the activity of my Return to Work Action Plan.

	<i>Day Month Year</i>			<i>Day Month Year</i>
<i>(Participant's Signature)</i>		<i>(Referred by: Designated Authority)</i>	<i>(Print Name)</i>	

TO BE COMPLETED BY HRDC CONTACT PERSON FOR HRIF ELIGIBILITY PURPOSES

CLAIM STARTS ON:	<i>Day Month Year</i>	CLAIM ENDS ON:	<i>Day Month Year</i>	WEEKS ENTITLED:	
E.I. BENEFIT RATE: \$	/WK	<i>(Please check box that applies):</i> <input type="checkbox"/> DOES NOT QUALIFY FOR BENEFITS			
		<input type="checkbox"/> HRIF ELIGIBLE <input type="checkbox"/> REACH BACK CLIENT <input type="checkbox"/> NOT HRIF ELIGIBLE			
				<i>Day Month Year</i>	
<i>(Agent's Signature)</i>		<i>(Print Name)</i>	<i>(HRDC Office)</i>		

Fax Info Back To:	Fax: (204)	Phone: (204)
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