

Please print :				Income Support Member ID <i>(for office use only)</i>			
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.				Employment Supports Referral ID			
Last Name				First Name			
Date of Birth	Day	Month	Year	Verified? <i>(for office use only)</i>			
				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Address							
City						Postal Code	
Home Telephone / TTY ()			Work Telephone ()			Ext.	
Email Address (not required)							
Are you legally allowed to work in Canada?						Verified? <i>(for office use only)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please check the box that applies:

- | | |
|--|--|
| <input type="checkbox"/> I am looking for work
<input type="checkbox"/> I am working part-time/full time
<input type="checkbox"/> I am self-employed
<input type="checkbox"/> I am doing volunteer work | <input type="checkbox"/> I have a job offer
<input type="checkbox"/> I am attending school
<input type="checkbox"/> I am in a training program |
|--|--|

Why are you applying to ODSP Employment Supports?:

- ☐
- I want to find a job
-
- ☐
- I need help keeping my job / maintaining my business
-
- ☐
- I want to become self-employed

If you are already working, why are you applying for ODSP Employment Supports?:

- | | |
|--|---|
| <input type="checkbox"/> I want to solve/fix a problem at work
<input type="checkbox"/> I need to change jobs because of my disability
<input type="checkbox"/> I need assistance with my business | <input type="checkbox"/> I want to advance in my current job
<input type="checkbox"/> Other; please describe _____

_____ |
|--|---|

Do you, or did you, receive money or other benefits/services from any of the following? Please check off any of the boxes that apply:

<input type="checkbox"/> ODSP Employment Supports _____	(Year) _____	<input type="checkbox"/> ODSP Income Support _____	(Year) _____
<input type="checkbox"/> Ontario Works _____	(Year) _____	<input type="checkbox"/> Workplace Safety & Insurance (WSIB) _____	(Year) _____
<input type="checkbox"/> Canada Pension Plan (CPP) _____	(Year) _____	<input type="checkbox"/> Employment Insurance (EI) _____	(Year) _____
<input type="checkbox"/> Accident, Sickness, Disability Insurance _____	(Year) _____	<input type="checkbox"/> Ontario Student Assistance Program (OSAP) _____	(Year) _____
<input type="checkbox"/> Other (please explain) _____	_____		(Year) _____

What is your disability: (*You may check more than one box*)

<input type="checkbox"/> Physical / Mobility	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Mental Health / Psychiatric	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Blind / Visually Impaired	<input type="checkbox"/> Head Injury / Cognitive
<input type="checkbox"/> Deaf / Hard of Hearing	<input type="checkbox"/> Other _____

Please tell us about your disability. If you need more space, please attach a separate page.

How does your disability make it difficult for you to get or keep a job?

- Did your disability result from an accident or illness at work? ☐ Yes ☐ No ☐ N/A
- Did your disability result from an automobile accident that occurred after June 21, 1990? ☐ Yes ☐ No ☐ N/A
- Have you filed a lawsuit regarding your disability? ☐ Yes ☐ No ☐ N/A
- Are you participating in any drug or alcohol recovery programs? (Not including AA or NA) ☐ Yes ☐ No ☐ N/A

If you answered yes to any of the 4 questions above, please describe:

Please check off any of the following that apply to you:

- ☐ I am a person with a disability in receipt of ODSP Income Support:

Member ID # (if known) _____

- ☐ I am registered as legally blind with the Canadian National Institute for the Blind (CNIB):

Registration number _____

If you checked off either of the 2 boxes above, you are not required to complete the attached Verification of Disability/Impairment form.

- ☐ I am a former/current student of a school or program for students with disabilities. Please attach a school or program report or other documentation of your attendance.

- ☐ I have a report completed by a Health Care Professional which describes my disability (for example: a medical form to apply for an accessible parking permit, or a psychologist report confirming a disability).

If you checked off either of the 2 boxes above, you may not be required to complete the attached Verification of Disability/Impairment form. Please contact your ODSP Office for more information.

In order for you to meet or talk with Employment Supports staff, do you require any special accommodations? (For example, a sign language interpreter)

- ☐ Yes ☐ No

If yes, please specify: _____

I hereby certify that the information provided is true and correct to the best of my knowledge.

Signature of applicant	Date (yyyy/mm/dd)
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Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)

The information is collected under the legal authority of the *Ontario Disability Support Program Act*, S. O. 1997, c.25, Schedule B, sections 32 and 33 for the purpose of providing employment supports to enable persons with disabilities to obtain and maintain employment. For more information contact

_____ at (_____) _____ ,
in your local Ontario Disability Support Program Office.

Office use only	<input type="checkbox"/> Eligibility verified <input type="checkbox"/> Not eligible	Signature of Ministry official	Date (yyyy/mm/dd)
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I, _____, * consent to the
Name of Applicant (*please print*)

exchange of information between the Ministry of Community and Social Services and

- the Government of Canada,
- the government of any other province or territory,
- the Government of Ontario,
- any agency, ministry or department of any of the foregoing,
- any community agency or employment service provider or organization,

in order to verify information (e.g., that I am not in receipt of other public or private assistance or eligible for such assistance, that I am a resident of Ontario, that I am legally entitled to work in Canada, etc.) specifically and exclusively for the purpose of determining or verifying my initial or ongoing eligibility for Employment Supports under the *Ontario Disability Support Program Act, 1997*.

I understand that this exchange of information may take the form of telephone conversations, face-to-face meetings, sending letters or records by mail or facsimile, or electronic data exchanges.

I further understand that information may be exchanged with my service provider(s) for the purpose of completing my employment supports plan and/or monitoring my progress as outlined under the terms and conditions of my Employment Supports Funding Agreement (ESFA).

In the event that I request a review of any decisions made by the Ministry regarding my initial or ongoing eligibility for Employment Supports under the *Ontario Disability Support Program Act*, I acknowledge that any or all of the information provided pursuant to this consent may be released to the Dispute Resolution Committee.

Date (*yyyy/mm/dd*)

**

Signature of Witness

*

Signature of Applicant

Name of Witness (*please print*)

* In situations where the applicant is unable to provide consent in writing, by reason of physical or mental disability, the consent of the trustee, legal guardian or, if there is no legal guardian, the next of kin (with the applicant's verbal consent), will suffice.

**Please have your signature witnessed by anyone over the age of 18 years.