Ontario

Ministry of Community and Social Services

Ontario Disability Support Program
EmploymentSupports

# Application for Employment Supports

Print Form

Please **print**:

Income Support Member ID *(for office use only)*

☐ Mr. ☐ Ms. ☐ Mrs.

Employment Supports Referral ID

Last Name

First Name

Date of Birth | Day | Month | Year

Verified? *(for office use only)*
☐ Yes ☐ No

Address

City

Postal Code

Home Telephone / TTY
( )

Work Telephone
( ) Ext.

Email Address (not required)

Are you legally allowed to work in Canada?
☐ Yes ☐ No

Verified? *(for office use only)*
☐ Yes ☐ No

Please check the box that applies:

- ☐ I am looking for work
- ☐ I am working part-time/full time
- ☐ I am self-employed
- ☐ I am doing volunteer work
- ☐ I have a job offer
- ☐ I am attending school
- ☐ 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?:

- ☐ I want to solve/fix a problem at work
- ☐ I need to change jobs because of my disability
- ☐ I need assistance with my business
- ☐ I want to advance in my current job
- ☐ Other; please describe _____





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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:

| | | | |
|---|---|---|---|
| ☐ ODSP Employment Supports | _____ (Year) | ☐ ODSP Income Support | _____ (Year) |
| ☐ Ontario Works | _____ (Year) | ☐ Workplace Safety & Insurance (WSIB) | _____ (Year) |
| ☐ Canada Pension Plan (CPP) | _____ (Year) | ☐ Employment Insurance (EI) | _____ (Year) |
| ☐ Accident, Sickness, Disability Insurance | _____ (Year) | ☐ Ontario Student Assistance Program (OSAP) | _____ (Year) |
| ☐ Other (please explain) | _____ | | _____ (Year) |

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

☐ Physical / Mobility
☐ Mental Health / Psychiatric
☐ Blind / Visually Impaired
☐ Deaf / Hard of Hearing
☐ Developmental Disability
☐ Learning Disability
☐ Head Injury / Cognitive
☐ 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?





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| | | | |
|---|---|---|---|
| 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 <u>not</u> 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 <u>may not</u> 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: _____





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

| Signature of applicant | Date *(yyyy/mm/dd)* |
|---|---|
| | |

**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** | ☐ Eligibility verified<br>☐ Not eligible | Signature of Ministry official | Date *(yyyy/mm/dd)* |
|---|---|---|---|
| | | | |





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# Consent to Disclose and Verify Information

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.

  

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