



Adult Learning and Training Supports Overview (ALTS) APPLICATION PACKAGE

PART 1. Client completes client information.

PART 2. Client completes

(Optional) "Request for Childcare Assistance Form

Client completes

"Request for Disability Assistance Form

If you have any questions, please contact your regions career development office.

NOTE: Applicants must submit their ALTS form thirty (30) days prior to the start date of the course.





ADULT LEARNING AND TRAINING SUPPORTS (ALTS) OVERVIEW

APPLICATION PACKAGE

ALTS PROGRAM INFORMATION

Eligible Clients may access a variety of services, including financial and career counselling, that will ultimately reduce their barriers to employment.

Please Note: Students must apply thirty (30) days prior to the course start date!

- Clients are encouraged to make contributions and commitments to their training/employment plan;
- All adult residents are eligible to receive assistance from CDOs;
- CDOs use a Client-centered approach
- Clients are approved for sponsorship based on funding eligibility requirements and their personal case history as well as an assessment completed by the CDO;
- Only those Clients who meet the program criteria and are deemed eligible will receive funding;
- Funding for full-time attendance in education and training programs is supported at different levels;
- Client sponsorship is an agreement between the Client and the Department of Family Services and both parties have responsibilities related to this agreement;
- Client supports are both an opportunity and a privilege;
- Funding available for sponsorship is limited; and
- Program priorities may shift from year-to-year based on changes in the labour market and on annual priorities established by the Department.



Adult Learning and Training Supports (ALTS) Disability Training Supports

OVERVIEW

PROGRAM OBJECTIVES

That persons with disabilities or those who face persistent barriers to training have equal opportunities available to them.

ELIGIBLITY

Clients ages 16 years or older, employed or underemployed entered into a training program. ALTS eligible.

TRAINER QUALIFICATIONS

Training programs must be ALTS eligible.

All programs under 1 year in duration.

Nunavut Arctic College.

ELIGIBLE EXPENSES

Eligible expenses are costs associated with accommodations required by the client, that meet the overall goal of finding and maintaining training. Some examples of provided training supports include:

Training Supports:

- Helping prepare for training
- Help finding training
- Help complete training
- Job coaching
- · Software and Mobility Devices
- Transportation Assistance
- Assistive Devices
- Tools and equipment, you need for your training
- Special clothing

HOW TO APPLY

Please contact your regions career development office for more information on the ALTS Disability Support Program.

careerdev@gov.nu.ca





ADULT LEARNING AND TRAINING SUPPORTS (ALTS) APPLICATION

PERSONAL	NFORMATIO	ON						
Last Name			First Name		Middle Name(s)	Gender ☐ M ☐ F ☐ Other		
Social Insurance Number			Date of B	Date of Birth		Nunavut Health Card Number		
			(MM-DD-YYYY)					
Family Type:	☐ Children in Ho	useholo	☐ No Children in Household		Number of Dependents:			
Marital Status:	☐ Single	□ Ма	rried	☐ Common La	aw			
Language(s) spoken:	☐ English	□ Fre	ench	☐ Inuktitut	☐ Inuinnaqtun	☐ Other:		
Language(s) written:	☐ English	□ Fre	ench	☐ Inuktitut	☐ Inuinnaqtun	☐ Other:		
Indigenous Identity:	☐ Inuit	☐ Firs	st Nation ☐ Métis ☐ NTI Card Nun			nber:		
Citizenship:	☐ Canadian	□ Pe	rmanent Resident			າ):	· · · · · · · · · · · · · · · · · · ·	
Visible Minority:	☐ Yes	□ No		☐ Prefer not t	o report			
Immigrant:	☐ Yes	□ No		Immigration ye	ear:		_	
Do you identify as havi (Examples include but not or coordination difficulties,	limited to: hearing, vis		nobility impai	rment, learning disa		ifficulties, trauma history, motor pain, other)	skills	
1						Learning ☐ Motor Skills	□ Speaking	
☐ Other (persistent ba	arriers)							
CONTACT IN	IFORMATIO	N						
P.O. Box Number			Commu	nity		Territory/Province		
Postal Code			Email		Telephone (Home)			
Telephone (Cell)			Telepho	ne (Work)		Preferred method of		
()			()		☐ Email ☐	Mail	

Return to: Your regional Career Development Offices

North Baffin: 1-800-567-1514 Career Development Box 204, Pangnirtung, NU X0A 0R0 northbaffincdo@gov.nu.ca South Baffin: 1-855-975-6580 Career Development Box 1000 Stn 1260, Iqaluit, NU X0A 0H0 southbaffincdo@gov.nu.ca Kivalliq: 1-800-953-8516 Career Development Box 877, Rankin Inlet, NU X0C 0G0 kivalliqcdo@gov.nu.ca Kitikmeot: 1-800-661-0845 Career Development Box 20, Cambridge Bay, NU X0B 0C0 kitikmeotcdo@gov.nu.ca

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EDUCATION HISTORY									
Highe	est level of education co	mpleted?		Place of Education					
Name of Institution				End Date:					
Traine of institution				Liid Date	·	(MM-DD-YYYY)			
List any training or educational programs you have completed.									
PROGRAM INSTITUTION				LOCATION START DATE GRADU					
1						MM - YYYY	MM - YYYY		
2									
3									
	MPLOYMENT I								
	☐ Self-Employed	-time/Temp/Casual) □ Empl	oyed (Full-time/Te oyed (Part-time/P	ermanent)	☐ In training	/Education			
Curre	nt Employer (Business/	Organization):		Employer ()	Telephone Num	ber:			
Empl	oyer Address:								
Rece	nt Employment Histor	ு: Please list most recent emp	oloyment first.						
(COMPANY NAME	JOB TITLE	DUTIE	S	FULL-TIME/ PART-TIME	REASON FOR LEAVING	PERIOD OF EMPLOYMENT		
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (MM-YYYY)		
					☐ PT Temp ☐ FT Perm		To (MM-YYYY)		
					☐ FT Temp ☐ PT Perm ☐ PT Temp		From (MM-YYYY) To (MM-YYYY)		
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (MM-YYYY)		
					☐ PT Temp		To (MM-YYYY)		
Are y Reas	ou willing to move for e ons:	mployment?	☐ Yes	□ No					
Are y Reas	ou willing to move for tr	aining?	☐ Yes	□ No					

DRI	VER'S LICENSE					
Do you	have a valid driver's license?	☐ Yes ☐ No				
	What type (class) of license is it?					
	☐ Class 1: Tractor Tra	iler Rigs	□ Class 5: Med	dium and small motor vel	hicles up to 11 000 kg	
☐ Class 2: Buses exceeding 24 passengers ☐ Class 6: Motorcycle						
			ng 11,000 kg □ Class 7: Lea	•		
	☐ Class 4: Medium ar	nd small taxicab/ ambulance		•		
Do you	have your airbrakes endorsement?	Yes 🗆 No				
TRA	AINING OR PROGRAM	I INFORMATION				
Program	n Name		Program Start Date:	Progran	n End Date:	
			(MM-DD-YY	YY)	(MM-DD-YYYY)	
Institutio	n Name		Program Location			
	*Assistance for eligible homeowners/leasing etc, while paying for an additional residence during training. Mortgage or rental agreement required. Disability Assistance *Assistance to purchase assistive devices/equipment or accommodations to support disabled individuals in completing their training. Books (Maximum allowable amount: \$500.00/intervention) *Assistance to purchase educational materials. Receipts required for reimbursement. Special Equipment (Maximum allowable amount: \$500.00/intervention) *Assistance to purchase training equipment. Receipts required for reimbursement.					
	Weekly Training Allowance *Financial Support for living expe Tutoring					
	*Assistance for tutoring costs. Re	, ,	sement.			
	Travel Assistance to Training L *Return airfare for client only.	ocation				
	Tuition					
	GIBILITY AND FUNDI		「ION ☐ Yes ☐ No		_	
NOTE: I	f you checked "Yes", please identi	y benefit type and start date	e:			
	□R	egular 🔲 Parer	ntal 🗆 Sick	☐ Special		

Start Date:

(MM-YYYY)

Are you receiving	g Income Support?	☐ Yes	□ No
Examples may inc	iny accommodations in the work place or training environment?		
materials, visual a	aids, other), adaptive furniture, visual training materials, tutoring, extra t	raining time, accor	mmodated test taking, other.
BANKIN	G INFORMATION		
Name of Bank			
Please provide	a voided cheque along with training information to receive di	rect deposit.	
CLIENT I	DECLARATION AND CONSENT TO RELEA	ASE PERSO	ONAL INFORMATION
Ι,	PLEASE PRINT YOUR FULL NAME SO	CIAL INSURANCE	, hereby declare that:
1. T	The information contained in my application for assistance is compl	ete, accurate and	I true, to the best of my knowledge.
	understand that false or misleading statements may result in legal o participate, including the termination of my benefits and repayme		
3. I	shall immediately notify the Department of Family Services should	the circumstance	es of my eligibility or participation change.
4. I	agree that if I have provided an email address, this will be the primary	nary means of cor	mmunication with me regarding my program.
5. I	agree to refund any financial assistance to which I am not entitled.		
	authorize and consent to the Government of Nunavut releasing, sl pouse and/or my dependents to any agency, organization or other		
	 a) Determining my initial and ongoing need, eligibility, or including financial assistance; 	or entitlement for	programs or services,
	b) Determining my status in participating, attending or m	naking progress in	programs and services; or
	c) Determining the results or outcomes from my partici	pation or enrolme	ent.
Da	ated this Day of	_20	
	Client Signature	_	
_	Witness Signature	_	





Adult Learning and Training Supports (ALTS)

REQUEST FOR CHILDCARE ASSISTANCE

IMPORTANT

Your family cannot be paid as your childcare provider if living in the same household.

PERSONAL INFORMATION									
Last	Name		First Name						
Spou	se Last Name		Spouse First Name						
Spou	se Employer		Spouse Employer Telephone Nu	mber					
			()						
NOT	rE : Only public daycares are eligible and must be utilized	I for the purpo	oses of reimbursment.						
	DEPENDANT CHILDREN (Dependant	children must	be financially dependant on you a	and under the age of 7.)					
	GIVEN NAME		LAST NAME	DATE OF BIRTH MM-DD-YYYY	AGE				
1									
2									
3									
4									
5									
6									
7									
8									
Who	will be your childcare provider?								
Addi	tional Comments:								

NOTE: *Receipts are required for reimbursment.*

Clients on Income Support may receive childcare subsidy through ATLS <u>if</u> they are not receiving the Daycare Subsidy (DTS).



Adult Learning and Training Supports (ALTS)

REQUEST FOR DISABILITY ASSISTANCE

This section is to be filled out by the individual requesting disability training supports.

CLIENT INFORMATION						
Last Name	First Name Mid		le Name(s)	Gender		
				□ M □ F □ Other		
Social Insurance Number	Date of Birth	Nunavut Health Card Number				
	(MM-DD-YYYY)					
CONTACT INFORMATION						
P.O. Box Number	Community		Territory/Province			
Postal Code	Email		Telephone (Home)			
			()			
Telephone (Cell)	Telephone (Work)		Preferred method of communication:			
()	()		☐ Email ☐ Mai	I 🗌 Telephone		
NATURE OF DISABILITY						
Do you identify with having a disability? $\hfill\Box$ Yes	☐ No ☐ Prefer not to report					
Type of Disability						
☐ Agility ☐ Hearing ☐ Mental Health ☐ Vis	ual □ Intellectual □ Developmental □ L	_earnir	ng □ Motor Skills □ S	peaking		
☐ Other (persistent barriers)						
Please describe the nature of your disability and/or persistent barriers and the impact your disability has on your ability to attend training opportunities.						

All sections are mandatory - Place a dash or line through boxes that do not apply to you.

To the best of your ability, please identify what disability related support(s) you require.					
Requested Support:					
How will the support(s) requested assist you with training?					
Have you received disability training support(s) before? If so, when?					

BUDGET

DESCRIPTION OF SUPPORTS REQUESTED

Please describe in the table below what support you are requesting, how long the support is needed, and the total cost of each support identified (if applicable). If you are unaware of the total cost of the support, assistance can be provided to you. Please provide a quote with this application if applicable.

	Description of support requested	Durationt of support	Cost of support			
		Quantity	Cost per Unit (A)	Shipping Cost (B)	Total Cost (A+B)	
1.						
2.						
3.						
4.						
5.						
Total Cost of Support (s) Requested						\$