



# Workplace Support Program Application for Employment Attendant

This form must be completed by the applicant when requesting for funding through the Employment Attendant component of the Workplace Support Program.

**Note:** This program has a limit of up to a maximum of **\$20,000 per year** plus Mandatory Employment Related Costs (MERC) as a contribution to the salary of an Employment Attendant. Additional **\$1000** contribution for payroll and job advertisement.

## 1 Provide personal information

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ Province: Nova Scotia, Canada Postal code: \_\_\_\_\_

Phone number: (xxx xxx-xxxx) \_\_\_\_\_ Alternate phone number: (xxx xxx-xxxx) \_\_\_\_\_

E-mail address : \_\_\_\_\_

Annual net income as reported on your most recent Notice of Assessment from Canada Revenue Agency \$: \_\_\_\_\_

## 2 Provide employment information

Name of company: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Canada Postal code: \_\_\_\_\_

Phone number: (xxx xxx-xxxx) \_\_\_\_\_ E-mail address : \_\_\_\_\_

Position: \_\_\_\_\_ Type of work: \_\_\_\_\_

Number of hours of work per week: \_\_\_\_\_ Contact name: \_\_\_\_\_

## 3 Provide the types of support required from an Employment Attendant

Number of hours of support required per week : \_\_\_\_\_

Amount per hour to be paid \$: \_\_\_\_\_

Amount requested for payroll service \$: \_\_\_\_\_

Amount requested for Employment Attendant \$: \_\_\_\_\_

## 4 Provide additional information

Yes No Have you explored whether technical aids and/or assistive devices can be used to reduce barriers in the workplace?

Yes No Are you in receipt of Workers' Compensation?

- Yes No Are you in a Workers' Compensation Appeal?
- Yes No Are you in receipt of Canada Disability Pension?
- Yes No Have you ever served in the Military and may be eligible for supports under the Canada Veteran's Rehabilitation Act?
- Yes No Are you receiving funds for an employment attendant such as Self-Managed Care Program?

## 5 Information required for statistical purposes

TEAM Work Cooperative requires the following information from individuals receiving support through this program.

Number of hours working per week : \_\_\_\_\_ Hourly wage earned \$: \_\_\_\_\_

Level of education:      Less than high school      Completed high school      Trade certificate      Diploma      University degree

## 6 Sign consent and date

Checking the box below indicates you have read and understood the consent statements.

I certify that the information given on this form is complete and accurate.

I understand that TEAM Work Cooperative collects personal information for the purpose of assessing my eligibility for this program. Collection, use and disclosure of personal information is governed by the Freedom of Information and Protection of Privacy Act.

I understand that my information may be shared with the Department of Community Services if requested.

Name: \_\_\_\_\_

(Please print)

Signature: \_\_\_\_\_ Date: (dd/mm/yyyy) \_\_\_\_\_

## 7 Attach the following information to your application

Letter, note or specialized assessment and recommendation from an appropriate medical practitioner outlining details and level of support required (e.g., occupational therapist)

Copy of Notice of Assessment from Canada Revenue Agency verifying annual net income and, if self-employed, a copy of your most recent T2125 (Part 1 to Part 5)

## 8 Submitting your application

Forms and attachments can be sent by:

- Handing over to the TEAM Work Cooperative office
- or mail to:-  
*TEAM Work Cooperative*  
*Workplace Support Program*  
*7051 Bayers Rd, Suite 501*  
*Halifax, Nova Scotia B3L 2C1*
- or scan and e-mail to [workplacesupportprog@teamworkbridge.org](mailto:workplacesupportprog@teamworkbridge.org)