

## APPLICATION FORM

Please check box for program applying to:  JUMP (Winkler)  OPPs (Winkler)

<p><b>To be Completed by Segue Personnel</b> Date Received: _____ Intake Interview Date: _____</p> <p>Interviewers: _____</p>
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**To Be Completed by Applicant** \*\*\* Please fill in ALL blanks. If it does not apply, write **N/A** \*\*\*

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.I.N. \_\_\_\_\_  
DD/MM/YY

Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Gender: Female  Male

PHIN: \_\_\_\_\_ MHSC: \_\_\_\_\_  
Personal Health Information Number - 9 digits Manitoba Health Services Card - 6 digits

Street Address: \_\_\_\_\_ City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Years at Current Address: \_\_\_\_\_

Mailing Address: (if different from above) \_\_\_\_\_

E-mail: \_\_\_\_\_ Marital Status: Single  Married  Divorced  Separated

Number of Children: \_\_\_\_\_ List age of each child: \_\_\_\_\_

Do you have dependable childcare? Yes  No  Child Care Provider: Private  Public  Family

Contact in case of emergency: \_\_\_\_\_  
Name Phone Number Relationship

Driver's License: No  Yes  DL# \_\_\_\_\_ Expiry Date: \_\_\_\_\_ Class: \_\_\_\_\_ Access to a vehicle: Yes  No

Primary/Secondary Education: Highest Grade Completed \_\_\_\_\_ Year \_\_\_\_\_ School \_\_\_\_\_  
School Name/ Location

If applicable, was your High School Diploma: Regular  Modified  Adapted  Vocational  \_\_\_\_\_  
Area of Training

Trade School or Other Training or Certifications: \_\_\_\_\_

College/University: \_\_\_\_\_  
Name Degree/Certificate/Diploma/ Area of Study Year Completed

Are you interested in further education? Yes  No  What sort of education would you consider? \_\_\_\_\_

Describe your interests, hobbies, or special abilities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Income Source:** Employed  \_\_\_\_\_ hours per week Unemployed  since: \_\_\_\_\_  
Date

Financial Support from Family  None  Band  EIA  EI  Date Coverage Expires: \_\_\_\_\_

Worker, if applicable: \_\_\_\_\_  
Name Phone Number

**Aboriginal Status:** Non-Aboriginal  Inuit  Metis  Status On-Reserve  Status Off-Reserve  Non-Status

**Are you a member of a visible minority?** (Non-Caucasian other than Aboriginal; visible disability) Yes  No

**Are you an immigrant or refugee?** Yes  No  Landed Date: \_\_\_\_\_

**Please list your last three places of employment:**

**1) Employer:** \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Type of work/duties: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Supervisor: \_\_\_\_\_ May we contact them? Yes  No  Phone # \_\_\_\_\_

If no, why? \_\_\_\_\_

**2) Employer:** \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Type of work/duties: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Supervisor: \_\_\_\_\_ May we contact them? Yes  No  Phone # \_\_\_\_\_

If no, why? \_\_\_\_\_

**3) Employer:** \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Type of work/duties: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Supervisor: \_\_\_\_\_ May we contact them? Yes  No  Phone # \_\_\_\_\_

If no, why? \_\_\_\_\_

**Explain any gaps in your employment and any other employment experiences:**

\_\_\_\_\_  
\_\_\_\_\_

**Previous Volunteer Work:**

1. Name of Agency/Organization: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Type of work/duties: \_\_\_\_\_

2. Name of Agency/Organization: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Type of work/duties: \_\_\_\_\_

**Describe Any Specific Skills Obtained:** \_\_\_\_\_

**Other involvements** (church, youth group, camp, clubs, etc.):

\_\_\_\_\_

**Describe the type of work you would enjoy:** \_\_\_\_\_

**What type of work environment would you prefer?** Indoor  Outdoor  Retail  Manufacturing

**Available hours of work** Daytime  Evenings  Shift Work  Weekends

**Describe any medical issues, challenges or barriers you may have to obtaining employment, i.e. mental health diagnosis, learning challenges, intellectual or physical disability, etc. Please specify:**

\_\_\_\_\_  
\_\_\_\_\_

**How did you find out about this program?** \_\_\_\_\_  
Name Agency Address Phone Number

**References:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I certify that information contained in this application is true and complete. I understand that false information may be grounds for contact with referral office or for immediate termination of any Segue programs. I authorize the verification of any or all information listed above.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Personal Information Declaration of Confidentiality

I, \_\_\_\_\_, the participant, agree with the following statements:

I understand that Segue Career Options shall keep in confidence and trust all information which may have been communicated to, acquired, or learned by its staff in the course of their employment, unless authorized in writing by the participant.

I understand that all information that I disclose on my application for participation, potentially within the classroom portion of the program, throughout my employment, and onwards will be used for statistical purposes for program funding. I also understand that information will only be shared with other organizations when it applies to my eligibility or involvement within Segue Career Options with authorization from the participant. Segue Career Options shall use the confidential information only for the purpose of evaluating participant work experience, participant employment, and/or employment relationships. I understand that Segue Career Options will store my confidential information through electronic and paper files.

I understand that I may come in contact with confidential information during my potential participation within a program with Segue Career Options. As part of the condition of my involvement with Segue Career Options, I hereby agree to keep in strict confidence any information regarding other participants that they disclose within their involvement with Segue Career Options, as well as any information obtained on a work placement or employment through Segue Career Options.

I understand that if I am not accepted into a program affiliated with Segue Career Options, the organization will continue to keep my personal information confidential.

I understand that under the Duty to Warn and Duty to Protect policies, Segue Employees may need to disclose confidential information if it pertains to, but is not limited to, potential harm to myself/another or criminal activity.

Upon inappropriate disclosure of information, or failure to abide by the following declaration the appropriate disciplinary actions will be implemented, which may lead to grounds for dismissal.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## RELEASE OF PARTICIPANT INFORMATION RELATED TO SEGUE PROGRAMS

Please complete, sign and date the following statement to affirm your consent. In doing so, Segue Career Options will be able to deliver the best possible services to meet your needs.

**If applicable, please indicate which services – counseling, benefits, job search assistance, etc. - you access through the following:**

EMPLOYMENT MANITOBA: Service: \_\_\_\_\_ Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

SOCIAL ASSISTANCE (EIA): Service: \_\_\_\_\_ Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

SOCIETY FOR MANITOBANS WITH DISABILITIES (SMD): Worker: \_\_\_\_\_ Ph.# \_\_\_\_\_

ADDICTIONS FOUNDATION OF MANITOBA (AFM): Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

CHILD & FAMILY SERVICES (CFS): In care? Yes  No  Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

COMMUNITY MENTAL HEALTH: Service: \_\_\_\_\_ Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

COMMUNITY LIVING MANITOBA: Service: \_\_\_\_\_ Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

MARKETABILITIES/VOC. REHAB: Service: \_\_\_\_\_ Worker: \_\_\_\_\_ Ph. # \_\_\_\_\_

PROCTOR OR OTHER (please specify): \_\_\_\_\_

I authorize SCO to obtain and share information about me from and to all applicable and necessary sources, e.g. service providers, agencies, educational institutions, family, healthcare providers, and other municipal, provincial and federal departments or corporations as listed above. This information may include details about my progress, employment assessments and plans, medical reports required for employment, work experience and availability.

**This information is protected under the Freedom of Information Act (FIPPA), Protection of Privacy Act and the Personal Health Information Act (PHIA).**

I hereby consent to release the information contained in this form regarding my participation in this program. I acknowledge that the information is collected and administered in accordance with the *Privacy Act* and applicable privacy laws and that it may be used to determine my eligibility for this program and for the evaluation and accountability of the program. Segue Career Options (SCO) requires personal information for the purpose of verifying your eligibility, enrollment and participation in programs and activities with SCO and other related or relevant programs. (This consent form is valid for 5 years after your file is closed. I understand that I may revoke this consent at any time with written notice to Segue Career Options. I also understand that in so doing I may become ineligible to receive services from SCO.)

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_