



Local Delivery Mechanism
53 Hwy. 551 P.O. Box 333
M'Chigeeng, ON P0P 1G0
Phone 705-377-5362 Fax 705-377-4980

Targeted Wage Subsidy Application

An application to the LDM for all programs must include all the following information:

- Participant Information Form
- Consent to the Request and Release of Information
- Up-to-Date Resume
- Request Letter (detailed) Include: name of employer / training provider, position, start date, duration, cost of tuition, if taking training, special clothing or equipment.
- Training/Work Plan (Employer completes this portion which is included in the package)
- 'Letter of Intent' to Hire the Trainee upon completion of Wage Subsidy (Employer)
- Schedule an appointment with LDM office: (In-Person, Phone or Email)

PLEASE SUBMIT YOUR COMPLETE APPLICATION PACKAGE TO:

Mailing Address:

M'Chigeeng Training & Employment Hub Center

Attn: Training Development Officer
P.O. Box 333, 53 Hwy.551
M'Chigeeng, ON P0P 1G0

Tel. #: 705-377-5362 x225

Fax #: 705-377-4980

Email: abbyp@mchigeeng.ca



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Participant Information Form

Last Name	First Name	Middle Name/Initials
Maiden Name(if applicable)	Date of Birth(MM-DD-YY)	SIN
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other		
Apartment/Unit #	Street Address or Box Number	
City/Town/Community	Province	Postal Code
Telephone Number	Other Number for Messages	
Email Address		
Languages Spoken <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> English & French <input type="checkbox"/> Aboriginal <input type="checkbox"/> Languages		
<input type="checkbox"/> Registered (status) Indian <input type="checkbox"/> Non-Status <input type="checkbox"/> Métis <input type="checkbox"/> Inuit		
Band Number		
First Nation Affiliation	<input type="checkbox"/> On Reserve <input type="checkbox"/> Off Reserve	
Disability <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)		
Source of Income		
Social Assistance Recipient (Provincial of First Nation) <input type="checkbox"/> No <input type="checkbox"/> Yes		
EI Claimant <input type="checkbox"/> Employment Insurance Claimant <input type="checkbox"/> Reach-Back Client <input type="checkbox"/> Non- Insured Client		
Gross Weekly Rate \$	Number of Weeks Entitled	
Other (please Specify)		
Have you collected Employment Insurance in past three years?		<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you collected Maternity or Parental Benefits in the past five years?		<input type="checkbox"/> No <input type="checkbox"/> Yes



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Education / Training Level

Highest level of education attained.

- | | | |
|---|--|---|
| <input type="checkbox"/> No formal Education | <input type="checkbox"/> Some Post-Secondary | <input type="checkbox"/> University Master's Degree |
| <input type="checkbox"/> Up to Grade7-8 (Secondary) | <input type="checkbox"/> Apprenticeship/Trade Certificate | <input type="checkbox"/> University Doctorate |
| <input type="checkbox"/> Grade9-10 (Secondary) | <input type="checkbox"/> College,CEGEP,or non-University | |
| <input type="checkbox"/> Grade11-12(Secondary) | <input type="checkbox"/> University Certificate or Diploma | |
| <input type="checkbox"/> Secondary School Diploma | <input type="checkbox"/> University Bachelor's Degree | |

Barriers To Employment (Choose all That Apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Language | <input type="checkbox"/> Physical, Emotional or Mental |
| <input type="checkbox"/> Lack of Labour Force Attachment | <input type="checkbox"/> Education | <input type="checkbox"/> Other Barrier Not Listed |
| <input type="checkbox"/> Lack of Work Experience | <input type="checkbox"/> Economic | |
| <input type="checkbox"/> Lack of Transportation | <input type="checkbox"/> Dependant Care | |
| <input type="checkbox"/> Lack of Marketable Skills | <input type="checkbox"/> Remoteness | |

Child Care

Dependents No Yes _____ Under 18 Years

Child Care Needed: (is childcare required for this Action Plan?) No Yes

Action Plan Childcare Funded (Choose type of support, if applicable)

- | | |
|--|---|
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> No Funding Received |
| <input type="checkbox"/> FNICCI | <input type="checkbox"/> Daycare Space Not Available |
| <input type="checkbox"/> EI/CRF | <input type="checkbox"/> Assisted by Family/Self-Funded |
| <input type="checkbox"/> Provincial Funding or Subsidy | |

Licenses & Certificates

Do you have a valid Driver's License No Yes If Yes, what type do you have: _____

Do you own Vehicle No Yes

Certificates (choose all that apply)

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> First Aid/CPR | <input type="checkbox"/> Smart Serve | <input type="checkbox"/> Customer Service |
| <input type="checkbox"/> Food Handler | <input type="checkbox"/> Babysitting | <input type="checkbox"/> Other: |



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LDM Receipts Agreement

Last Name First Name Middle

Permanent/ Temporary Address Telephone

I, _____, agree to submit all receipts to the M'Chigeeng First Nation Local Delivery Mechanism (LDM) office, with respect to my education, Training or Employment-related activities. Failure to do so, will result in an overpayment to the LDM program and a possibility in ineligibility for funding for a 2 year period.

Dated at _____ this _____ day of _____, 20____

Signature

Signature of Witness



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Training / Work Plan

Please be in depth and complete the training /work to be completes. This training/work plan will be used throughout the contract as a monitoring tool.

Trainee Information

Name of Trainee:		
Date of Program include: (day/month/year)		
From:	To:	#of Weeks:
Compensation:	Hours per week:	Training Plan Job Title/Course Name:
\$ /hr.	hours	

Host Company Information

Company/Institution:	
Address:	
Contact Name:	Title:
Phone:	Fax:
Number of Employee in Company:	In Business Since:
Revenue Canada Number:	GST Number:
Third Party Liability Insurance Yes <input type="radio"/> No <input type="radio"/> If yes, Carrier: _____ Policy Number: _____	List Location(s) where training will take place:

Training Plan Information

List the objectives of the training/ work plan:



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List the Chronological duties/skill of the training/work including approximate duration: (attach additional sheets if necessary).

Duties/Skills	Time Frame (weeks)

List the specialized equipment the trainee will use during the training period, if any:

What skills will the trainee acquire during the program:

How will the trainee's progress be monitored during the program: i.e. meetings, tests



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Will this position lead to full-time position within your place of business?
Is this a new position within your organization?
Have you contacted other funding agencies? If so, what was the outcome?

Budget Information –Complete the applicable sections. Actual contribution from the LDM will be negotiable once all information is presented.

Wage Details:	
_____ /hr x _____ hrs. per week x _____ weeks= _____	
Benefits @ 8% (includes vacation pay, E.I., WSIB, CPP)	= _____
sub-total	= _____
Tuition Details:	
Tuition	= _____
Books or Other Course Costs (please describe)	= _____
Other Expenses	
Please describe each item with cost:	= _____
	= _____
Total Amount: =\$ _____	
Employer's Signature:	Date: