



Adult Learning and Training Supports (ALTS) APPLICATION PACKAGE

If you have any questions, please contact your region's career development office.



PERSONAL IN	FORMATIO	N				
Last Name		First Name		Gender ☐ Male ☐ Female ☐ Unspecified		
					☐ Prefer not to report	
Social Insurance Number	er		Date of Birth		Nunavut Health Card Number	
			(YYYY-MM-D	D)		
Family Type:	☐ Children in Ho	usehold	☐ No Children in Household		Number of Dependents:	
Marital Status:	☐ Married or Equ	uivalent	☐ Single ☐ Prefer not to re		eport	
Language(s) spoken:	□English	□Fren	ch 🗆 Inuktitut	□ Inuinnaqtun	☐ Other:	
Language(s) <u>written</u> :	☐ English	☐ Frei	nch 🗆 Inuktitut	☐ Inuinnaqtun	☐ Other:	
Indigenous Identity:	□Yes	□No	☐ Prefer not to	report NTI Card	Number:	
Citizenship: ☐ Canadian ☐ Per		□ Per	manent Resident ☐ Other (Explain):	
Visible Minority:	□ Yes	□ No	☐ Prefer not to	report		
Immigrant:	☐ Yes	□ No	☐ Prefer not to	o report Immig	ration year:	
Do you identify as havir	ng a disability?	☐ Yes	☐ No ☐ Prefer r	not to report		
(Examples include but not l coordination difficulties, atte	imited to: hearing, vis ention difficulties, pro	ion, or mo blems wit	bility impairment, learning disab n memory, sensory processing o	ility, mental health diffi difficulties, chronic pair	culties, trauma history, motor skills or n, other)	
Type of Disability						
☐ Agility ☐ Hearing	☐ Agility ☐ Hearing ☐ Mental Health ☐ Visual ☐ Intellectual ☐ Developmental ☐ Learning ☐ Motor Skills ☐ Speaking					
☐ Other (persistent bar	riers)					
CONTACT INFORMATION						
P.O. Box Number			Community		Territory/Province	
Postal Code			Email		Telephone (Home)	
Telephone (Cell)			Telephone (Work)		Preferred method of communication:	
				EXT:	☐ Email ☐ Mail ☐ Telephone	

Form ID: Control #:



2

ΙĒ	DUCATION HIS	STORY						
Highest level of education completed?				Place of Education				
Name of Institution				End Date	: :			
						(YYYY-MM-DD)		
List any training or educational programs you have completed.								
	PROGRAM	INSTITUTIO	N	LOCATION START DATE GRADUATION DATE YYYY-MM				
1								
2								
3								
	MPLOYMENT H	HISTORY						
Current Employment Status □ Employed (Full-time/Permanent) □ Employed (Full-time/Temp/Casual) □ Employed (Part-time/Temp/Casual) □ Employed (Part-time/Permanent) □ In training/Education □ Self-Employed								
Curre	Current Employer (Business/Organization): Employer Telephone Number:							
Employer Address:								
Recent Employment History: Please list most recent employment first.								
COMPANY NAME JOB TITLE			DUTIES		FULL-TIME/ PART-TIME	REASON FOR LEAVING	PERIOD OF EMPLOYMENT	
					☐ FT Perm ☐ FT Temp ☐ PT Perm		From (YYYY-MM)	
					☐ PT Temp ☐ FT Perm ☐ FT Temp ☐ PT Perm		To (YYYY-MM) From (YYYY-MM)	
					□ PT Temp		To (YYYY-MM)	

Form ID: Control #:



DRIVER'S LICENSE						
Do you have a valid driver's license? ☐ Yes ☐ No What type (class) of license is it?						
□ Class 1: Tractor Trailer Rigs □ Class 5: Medium and small motor vehicles up to 11,000 kg □ Class 2: Buses exceeding 24 passengers □ Class 6: Motorcycle □ Class 3: Single bodied motor vehicles exceeding 11,000 kg □ Class 7: Learner's permit □ Class 4: Medium and small taxicab/ ambulance						
Do you have your airbrakes endorsement? ☐ Yes ☐ No						
TRAINING OR PROGRAM INFORMATION						
Program Name	Program Start Date:	Program End Date:				
	(YYYY-MM-DD)	(YYYY-MM-DD)				
Institution Name	Program Location					
Program Type □ Full-Time □ Part-Time	☐ Distance Educ	cation (Online)				
SPONSORSHIP SUPPORT REQUEST						
Check the support categories that you will require while you attend your education or training program. Tuition & Other Fees Allowance Books and Materials (Maximum Allowable Expense: \$1000/intervention) Tutoring Allowance (Maximum Allowable Expense: \$1000/intervention) Disability Support - Supporting Employment and Training (SET) ALTS Childcare Subsidy Training Allowance (Single Client) Training Allowance Top-Up (For Clients with Dependents) Living Alway from Home Allowance (Primary Residence) Living Away from Home Allowance (Student Residence) Travel Benefits (Single Client) Travel Benefits (Family) - Trades Education Programs Only						

Form ID: Control #:



ELIGIBILITY AND FUNDING DETERMINATION

Are you currently claiming Employment Insurance (EI) Benefits?

NOTE: If you checked "Yes", please identify benefit type and start date:

	☐ Regular	☐ Parental	☐ Sick	☐ Spec	cial	
	Start	Date:	(YYYY-MM)			
			(1111-IVIIVI)			
Are you an Income Assista	ance Recipient?			☐ Yes	□ No	
Have you graduated high	school or received your GE	D?		☐ Yes	□ No	
Do you owe any money to	the GN?			☐ Yes	□ No	
Are you a registered appr	rentice and will be receiving	El during Technical T	raining?	☐ Yes	□ No	
CLIENT DECLA	RATION AND CO	NSENT TO RE	LEASE PER	SONAL IN	FORMATION	
					<u> </u>	
l,	SE PRINT YOUR FULL NAME	,	SOCIAL INSURA	NOE NI IMBED	, hereby declare that:	
		- 4			hand of market and	
	ation contained in my applic		•		, ,	
I understand that false or misleading statements may result in legal action, criminal investigation, prosecution, and my ineligibility. to participate, including the termination of my benefits and repayment of any benefits I have already received.						
3. I shall imme	3. I shall immediately notify the Department of Family Services should the circumstances of my eligibility or participation change.					
4. I agree that	4. I agree that if I have provided an email address, this will be the primary means of communication with me regarding my program.					
5. I agree to re	5. I agree to refund any financial assistance to which I am not entitled.					
6. I authorize a spouse and	6. I authorize and consent to the Government of Nunavut releasing, sharing or verifying of information about me and/or my spouse and/or my dependents to any agency, organization or other government department for the following purposes:					
,	 a) Determining my initial and ongoing need, eligibility, or entitlement for programs or services, including financial assistance; 					
	b) Determining my status in participating, attending or making progress in programs and services; or					
	c) Determining the results	or outcomes from my	participation or er	rolment.		
Dated this _	Day of		20	_		
	Client Signatu	re				
	_					
	Witness Signate	ure				

☐ Yes ☐ No

Form ID: Control #:



REQUEST FOR CHILDCARE ASSISTANCE

■ IMPORTANT

CLIENT INFORMATION

Last Name

Middle Name

7

8

Please indicate the correct legal spelling of your first and last name as written on your Government Issued ID or attach a copy of a birth certificate to your application.

First Name

Date of Birth (YYYY-MM-DD)

SPOUSE INFORMATION								
Last Name			First Name					
Middle Name			Date of Birth (YYYY-MM-DD)					
MIN	OR DEPENDENT CHILDREN							
	FIRST NAME		LAST NAME	DATE OF BIRTH YYYY-MM-DD	AGE			
1								
2								
3								
4								
5								

Form ID: Control #:



REQUEST FOR FAMILY TRAVEL BENEFITS

I IMPORTANT

Family travel benefits are only available to clients attending trades education programs.

Please indicate the correct legal spelling of each family members first and last name as written on their Government Issued ID(s).

CLIENT INFORMATION	
Last Name	First Name
Middle Name	Date of Birth (YYYY-MM-DD)
SPOUSE INFORMATION	
Last Name	First Name
Middle Name	Date of Birth (YYYY-MM-DD)
MINOR DEPENDENT CHILDREN (Dependant children mu	ust be financially dependent on you and under the age of 18.)

MINOR DEPENDENT CHILDREN (Dependant children must be financially dependant on you and under the age of 18.)							
	FIRST NAME	LAST NAME	DATE OF BIRTH YYYY-MM-DD	AGE			
1							
2							
3							
4							

Form ID: Control #: