

**SIOUX LOOKOUT AREA ABORIGINAL MANAGEMENT BOARD
PROGRAM FOR THE DISABLED**

P In order for the Sioux Lookout Area Aboriginal Management Board to determine your eligibility to participate in the above-noted program, please complete the questionnaire as completely as possible. Failure to provide the information accurately could delay the start of your participation in the program.

Name: _____

Address: _____

Social Insurance Number: _____

Birth date: _____

1. Question: Do you have a long-term disability? Yes Q No Unsure

- Hearing
- H Speaking
- S Seeing
- S Mobility/Agility
- M Mental/Psychological
- M Attention Disorder
- A Learning Disabilities
- L Developmentally Delayed
- D Chronic Heart Condition
- C Arthritis/rheumatoid Arthritis
- A Fetal Alcohol Syndrome (FAS)
 Fetal Alcohol Effects (FAE)

- F Epilepsy
- E Diabetes with complications - Specify

2. Question: Do any of the following employment barriers apply to you?

- 2** English as a second language/dialect
- E Long-term Social Assistance Recipient
- L Criminal Record
- C Over 55 years of age
- O Over 18 but under 30 years of age
- O Single Parent
- S Illiteracy
- I Substance Addiction

Other - Specify

By signing the declaration form, I am verifying the above conditions and barriers relating to my participation in the program is correct and to the best of my knowledge and wish them to be held on confidentiality with the SLAAMB office.

Signature:_____ Date:_____