REQUEST FOR COMMUNITY VOLUNTEER SUPPLEMENT (CVS)

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. The collection, use and disclosure of personal information is subject to the provisions of the Freedom of Information and Protection of Privacy Act. Any questions about this information should be directed to your local Employment and Assistance Office.

SR Number:

The ministry may provide a community volunteer supplement of up to $100 for each calendar month for clothing, transportation or other expenses that are needed by the eligible person to participate in a community volunteer program.

DESCRIPTION OF VOLUNTEER PARTICIPATION

Name of the agency you will volunteer with:

Describe your participation with this volunteer agency. (What will you be doing?)

How often will you volunteer?

When will you start to volunteer with this agency? (YYYY MMM DD)

NOTICE: You must notify the ministry immediately if you cease to volunteer with the agency named above.

CONFIRMATION AND NOTIFICATION

I confirm that the information I have provided about my volunteer participation is true and correct. I understand that I am to notify the ministry immediately if I cease to volunteer with the volunteer agency named in this form. I also understand that the ministry may verify and obtain information from the volunteer agency I have named in order to confirm my eligibility and continued eligibility for this supplement.

CLIENT SIGNATURE WORKER SIGNATURE OFFICE CODE TELEPHONE

I understand that the ministry will verify that the client named above who is under 19 years of age is volunteering with this agency to ensure that eligibility requirements are met.

PARENT / GUARDIAN SIGNATURE WORKER SIGNATURE OFFICE CODE TELEPHONE

CONFIRMATION OF PARTICIPATION BY VOLUNTEER AGENCY

I confirm that ______________ is participating as a volunteer with:

NAME OF AGENCY

Confirmation of the client's participation with the agency named above.

AGENCY NAME MINISTRY CONTACT (IF KNOWN) TELEPHONE

ADDRESS MINISTRY OFFICE ADDRESS (STREET ADDRESS)

CITY POSTAL CODE TELEPHONE

SIGNING OFFICER OF THE AGENCY DATE (YYYY MMM DD)

MINISTRY WORKER SIGNATURE DATE (YYYY MMM DD)
The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the Employment and Assistance Act and the Employment and Assistance for Persons with Disabilities Act. The collection, use and disclosure of personal information is subject to the provisions of the Freedom of Information and Protection of Privacy Act. Any questions about this information should be directed to your local Employment and Assistance Office.

PERIOD OF ELIGIBILITY BEING REVIEWED (YYYY MMM DD):
FROM: ___________________________ TO: ___________________________

CLIENT'S SURNAME _______________ FIRST NAME _______________ INITIAL _______________ CASE # _______________ DATE OF BIRTH (YYYY MMM DD) _______________

NAME OF VOLUNTEER AGENCY: __________________________________________

HOW OFTEN DID THIS PERSON VOLUNTEER WITH THE AGENCY EACH MONTH?: __________________________________________

BRIEFLY DESCRIBE THE ACTIVITIES THE VOLUNTEER PARTICIPATED IN: __________________________________________

IS THIS PERSON STILL VOLUNTEERING WITH THE AGENCY? □ YES □ NO

IF NO, ON WHAT DATE DID THE PERSON CEASE TO VOLUNTEER WITH THE AGENCY? ___________________________

IF YES, PROVIDE DATES OF PARTICIPATION BELOW (YYYY MMM DD):
__________________________________________
__________________________________________
__________________________________________

CONFIRMATION OF PARTICIPATION BY VOLUNTEER AGENCY

I, ___________________________________________ am an employee of

NAME OF AGENCY ___________________________________________

and confirm that the information provided is correct.

AGENCY NAME ___________________________________________

MINISTRY CONTACT (IF KNOWN) ___________________________________________

ADDRESS ___________________________________________

MINISTRY OFFICE ADDRESS (STREET ADDRESS) ___________________________________________

CITY ___________________________________________

POSTAL CODE ___________________________________________

TELEPHONE ___________________________________________

SIGNING OFFICER OF THE AGENCY ___________________________________________

DATE (YYYY MMM DD) ___________________________________________

MINISTRY WORKER SIGNATURE ___________________________________________

DATE (YYYY MMM DD) ___________________________________________

Please send the completed form back to the ministry office at the address indicated above.