



Akwesasne Area Management Board

The objective of the Akwesasne Area Management Board (AAMB) is to provide assistance to clients in order to achieve their employment goals. This is done by assessing each client and hosting various levels of training which can include formalized classroom and on-the-job training. AAMB will participate in the development of special initiatives to meet the needs identified by clients and the community.

Current Programs of the A.A.M.B include:

Job Opportunity
Local Projects
Self-Employment Assistance

Job Creation Partnerships
Summer Career Placement

ELIGIBLE CLIENTS:

- Must be a member or probationary member of the Mohawks of Akwesasne or the Mohawk Nation Council of Chiefs – Mohawk Nation of Akwesasne;
- Must possess a valid Canadian Social Insurance Number (**MUST present card upon application**);
- Must be unemployed/employed disadvantaged, having multiple barriers in obtaining or maintaining permanent full-time employment; and
- Must not have participated in AAMB programs beyond the 208 week maximum

ELIGIBLE EMPLOYERS:

- Must have been in existence and fully operational for six (6) months or more;
- Must be registered with Revenue Canada and pay into Canadian Employment Insurance; and
- Must provide proof of insurance coverage (general liability for worksite and WSIB/CSST or comparable).

Employers who have been in existence and fully operational for six months or more, but are not registered with Revenue Canada may apply through any other eligible employer. Please contact office for further information on this process.

PROGRAM JOB OPPORTUNITY

The objective of this program is **to provide clients with work experience and training** that will lead to continued unsubsidized employment. Job Opportunity is a **client-centered** program and may be used as a stand-alone intervention (e.g. clients with required training and education who lack experience), or as one of a series of interventions (e.g. following successful completion of a training course).

There is a formal application form for employers interested in this program. Details to be provided include:

- Job title, job description and qualifications of position; length of project; financials;
- A Training Plan: If there is training purchased from an educational institution, provide confirmation of the course dates, costs, duration and course outline;
- Supervision, location and hours of work;
- How the client's training and work performance will be evaluated.

Financial Limitations

Wages:

As of April 1, 2016, the AAMB rate of reimbursement of client wages is up to a maximum of \$13.425/hr. or \$537/wk/participant for the first half of the project, then the AAMB's contribution decreases to \$10.069/hr. or \$402.75/wk/participant. The Employer is responsible for the Mandatory Employer Related Costs (MERC) which includes EI, 4% vacation pay, CSST or WSIB and CPP if applicable, and any top-up to the wages above the AAMB maximum.

Training Costs

A reimbursement for training costs may be negotiated up to a maximum of \$20/hour for off-site training. This training must occur during the 30-40 hour work week.

Special Costs/Special Costs for Disabled: negotiable

For complete information on the above or other programs, please contact:

Carmen Cook, Programs and Services Officer

ccook@aamb.ca

Katherine Cook, Programs and Services Officer

kcook@aamb.ca

P. (613)575-2626

F. (613)575-2863



Akwesasne Area Management Board

PO Box 965 Cornwall Ontario K6H 5V1
613-575-2626 Fax: 613-575-2863.
www.aamb.ca

This Form **MUST** be completed in **FULL** to be considered.

JOB OPPORTUNITY PROGRAM APPLICATION FORM

File #: JO-	REVENUE CANADA BUSINESS #PAYROLL # (mandatory): (if none – a third party sponsorship letter must be attached)
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Employer:	
Street Address:	City:
Province:	Postal Code:
Phone Number:	Alt. Phone Number:
Fax Number:	Contact Person:
Email Address:	Type of Organization: <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit

IS ORGANIZATION GOVERNED BY A BOARD? If Yes, a Resolution authorizing this application must be attached.
 YES NO

STATE THE MAIN PRODUCTS OR SERVICES OF YOUR COMPANY AND HOW LONG YOU HAVE BEEN OPERATING:
 (Must be fully operational for 6 months or more to be eligible)

PLEASE STATE THE OBJECTIVES, ACTIVITIES, AND EXPECTED RESULTS OF PROJECT: (attach separate page if necessary)

DURATION OF ACTIVITY: FROM: _____ TO: _____	LOCATION OF ACTIVITY:
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WILL THIS PERSON BE HIRED AT THE END OF THE PROJECT? YES NO

HAVE YOU ATTACHED A TRAINING PLAN FOR THIS PERSON? YES NO

Insurance Coverage:	WSIB/CSST FOR EMPLOYEES <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPREHENSIVE GENERAL LIABILITY FOR BUSINESSES <input type="checkbox"/> YES <input type="checkbox"/> NO
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HAVE YOU SUBMITTED AN APPLICATION ELSEWHERE? YES NO
 IF SO, INDICATE WHERE AND WHO THE CONTACT PERSON IS:

A.A.M.B. OFFICE USE ONLY:

ORG TYPE:	PROJECT OFFICER:	NOC CODE:	S.I.C. CODE:	ACTIVITY CODE:
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**FINANCIAL SUMMARY
WAGE COSTS**

OCCUPATIONS (1 per line) Col. 1	No. of Weeks Col. 2	Hours/Week Col. 3	Total Hours Col. 4 (2x3)	AAMB Wage rate/hr. (13.425/10.069) Col. 5	Employer Top up/hr.	Total rate/hr.
TOTAL:				1)		

EMPLOYER'S RESPONSIBILITY

MANDATORY EMPLOYER RELATED COSTS: _____ % X TOTAL WAGES = 2) (EI/4% Vacation Pay/CSST or WSIB/CPP)

TRAINING COSTS (details must be provided on the attached Training Plan Form)

Max: = \$20/hour x total number of training hours for off-site purchased training only.	TOTAL = 3)

SPECIAL COSTS/OF LEASING/PURCHASE EQUIPMENT (MAY be provided, MUST be specific to participant training)

Max: = \$5,000 (3 quotes MUST be obtained for Special Costs)	TOTAL = 4)

SPECIAL COSTS FOR THE DISABLED

Max: = \$10,000 per participant (3 quotes MUST be obtained for Special Costs for the Disabled)	TOTAL = 5)

TOTAL AAMB PROJECT COST (1 + 3 + 4 + 5):	6)
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FUNDS FROM OTHER SOURCES AND/OR EMPLOYER'S CONTRIBUTION

	TOTAL = 7)

	PROJECT GRAND TOTAL = 8)
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I/WE CERTIFY THAT EACH JOB TO BE REQUESTED IS IN ADDITION TO EMPLOYMENT PLANNED FOR THE PERIOD BEING PROPOSED.

_____ PRINT NAME	_____ TITLE	_____ SIGNATURE	_____ DATE
_____ PRINT NAME	_____ TITLE	_____ SIGNATURE	_____ DATE



AKWESASNE AREA MANAGEMENT BOARD
PO Box 965, Cornwall Ontario K6H 5V1 (613) 575-2626



A.A.M.B. USE
FILE #

TRAINING PLAN FORM

TRAINING (Outline Attached)		Provider	Dates/Total Hours	Cost
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site			
How will training / work performance be evaluated:				
Qualifications of Trainers (Resumes of Trainers should be attached if not provided by a recognized training institute):				