



## **Form HSD3267 – Two-Year Independence Assessment**

This form is used to demonstrate you have met the eligibility criteria of the two-year independence requirement for income assistance.

Return the completed form to your local employment and assistance office.

## TWO-YEAR INDEPENDENCE ASSESSMENT

The personal information collected on this form is subject to the provisions under section 26(c) of the *Freedom of Information and Protection of Privacy Act* and may be verified under the *Employment and Assistance Act* or the *Employment and Assistance for Persons with Disabilities Act*. If you have any questions regarding the information collected on this form, please contact your local Employment and Assistance Office.

### CLIENT INFORMATION

Surname	Given Name	Birthdate (YYYY MMM DD)
Address		Postal Code
Telephone	Message	Email Address

### ADDITIONAL ELIGIBILITY INFORMATION

(NOTE: Persons who have been designated as a person with disabilities are not required to complete this form.)

#### Past Employment

		Applicant 1	Applicant 2
1.	Were you employed for 840 hours in each year of any consecutive two-year period?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Was your income from employment at least \$7,000 in each year of any consecutive two-year period?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	If you were employed and paid for work performed only for a <b>portion</b> of a consecutive two-year period, for the remaining balance: a) were you waiting for or receiving benefits under the <i>Employment Insurance Act</i> (Canada)? OR b) were you receiving income under a private or public income replacement plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO

#### Exemptions (Complete only if ALL answers to questions 1 – 3 are NO.)

		Applicant 1	Applicant 2
4.	Are you pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Do you have a medical condition that: a) prevents you from working for at least 30 days from today's date; OR b) precluded you from working for at least 6 months of the last two years	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you been supported by an employed spouse for a consecutive two-year period? If for less than two years, for the remaining balance: a) Were you working? Please specify hours worked: _____ Income received: _____ OR b) Were you waiting for or receiving benefits under the <i>Employment Insurance Act</i> (Canada)? OR c) Were you receiving income under a private or public income replacement plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
7.	In the past two years, were you incarcerated in a lawful place of confinement for a total of six months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	When you turned 19 years of age: a) Were you in the care of the Ministry of Children and Family Development? OR b) Had you entered into a youth agreement?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO

9.	In the past six months, from the date of this application, did you separate from an abusive spouse, or leave an abusive relative? If this has impaired your ability to work, please indicate how: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
10.	Have you been granted a two-year certificate or diploma, or a bachelor's degree (or higher) from a post secondary institution?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	Are you providing care for a child under an agreement under the <i>Child, Family and Community Act</i> ?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
12.	Are you receiving assistance for a child who resides with you under an agreement under the Child in the Home of a Relative Program?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Client Signature	Please Print	Date Signed (YYYY MMM DD)
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