



Helping Kids with Physical Disabilities Succeed

## Incontinence Supplies Grant Program For Children and Youth with Disabilities Application Guidelines

**\*\*\*Please Keep these guidelines for your records and future reference\*\*\***

### 1. Who can apply?

Ontario residents ages 3 to 18 years of age with a valid Ontario health card, who have a chronic disability resulting in irreversible incontinence or retention problems lasting longer than 6 months requiring the use of incontinence supplies.

### 2. Who can not apply?

The program is **not** for children or youth residing in acute or chronic care hospitals. Children or youth who reside in Schedule I or II Ministry of Community and Social Services (MCSS) residential facilities provide incontinence supplies to their residents. Youth whose incontinence/retention problem is a result of a work related injuries are not eligible, the workplace & Insurance Board (WSIB) provides funding in such cases. Children whose health coverage is through the Interim Federal Health Program.

### 3. My Child lives in a Group Home, can I apply for funding assistance?

Yes, the child/youth must still meet the eligibility requirements.

### 4. How much money will I receive?

You may qualify for **one** of the following grants (the grant is a contribution towards the cost of supplies and may not cover all costs)

#### Grant level A (\$400/yr)

OR

#### Grant level B ages 6 –18 yrs (\$900/yr)

- Diapers (3-5yrs)
- Intermittent/Foley catheters
- Reusable cloth diapers /liners

- Diapers (6 –18 yrs)
- Male external catheters

**The grant DOES NOT cover costs for wipes, bed sheets, clothing (underwear), laundry detergent or pads for menstrual periods.**

**Note:** Children/youth requiring assistance with bowel management may be eligible for a **Level C grant (\$200/yr)**. Bowel Management Supplies included are enema administration kits, tubing or glycerin suppositories. It **DOES NOT** include Fleet enemas, prescriptions, medications (stool softeners, laxatives).

### 5. My child is under 3 years of age. Can we still apply?

Under normal circumstances, no. However, some children under 3 years may be eligible for assistance if they have a medical condition which results in the use of specialized diapers (ie. Prune Belly), catheters (ie. Spina Bifida) or a significantly larger than normal quantity of diapers (child with a vesicostomy).

### 6. Do I need to see my Doctor?

**YES.** Your child's Doctor or a Nurse Practitioner must fill out the medical portion of the application. They are required to certify that your child has a chronic disability requiring use of incontinence supplies and that they meet the criteria. The Doctor or Nurse Practitioner must be licensed to practice in the Province of Ontario and have a valid registration number.

### 7. How do I apply?

Fill out the application form and see your family Doctor or Nurse Practitioner. Make sure that all areas are completed and you have signed the form. If it is incomplete it will be returned to you and will delay the application process. **Please note:** the grant begins after the application is approved; the program is unable to provide retroactive payments.

Send the completed application to: **Incontinence Supplies Grant Program for Children and Youth with Disabilities**  
Easter Seals Ontario

One Concorde Gate, Suite 700  
Toronto, Ontario M3C 3N6

### 8. Do I need to apply every year?

**NO.** Once your application has been approved, Easter Seals Ontario will automatically send you a payment every 6 months. Easter Seals Ontario confirms with the Ontario Health Insurance Plan (OHIP) that you are still a resident of Ontario and that your child's health card is valid. A review of eligibility will occur approximately every two years.

### 9. Do I need to keep my receipts for the review?

**Yes.** You must keep all your receipts for the review (including grocery receipts if purchased when grocery shopping). As per the Ministry of Health and Long Term Care (MOHLTC) requirements, Easter Seals Ontario will audit you and ask that you produce receipts or photocopies of your receipts to confirm your grant. The grant will be temporarily suspended until you respond to the audit and may be fully cancelled if you are unable to show proof of need. Remember for income tax purposes you can only claim receipts for expenditures that exceed the amount of your grant. Original receipts will be returned on request.

## **Incontinence Supplies Grant Program For Children and Youth with Disabilities** **Application Guidelines Continued**

### **10. I have lost my child's Health Card and I now have a new one, do I have to notify you?**

**Yes.** Easter Seals Ontario automatically checks your child's health card number before your payment is issued with the health card database. If something does not match, your payment will not be issued.

### **11. Will the OHIP database tell Easter Seals Ontario, Incontinence Grant Program when I have changed my address or last name?**

**No.** It is important that you notify OHIP and us whenever you change your address or last name. Without this information your payments may not reach you.

### **12. How will payments be made?**

Every six months you will receive half of the approved grant. The first payment will be made approximately six weeks after the initial application is approved and then every six months after. Payments will be mailed to you unless you sign up for Direct Deposit into your bank account, page 3 of the application.

### **13. Will I ever need to send in another application form?**

**Maybe.** When your child turns 6 years old you may be eligible to apply for Level B (\$900) if the use of diapers is still required and your costs have increased to the higher grant amount. You must complete another application form, the increase **does not** occur automatically. The increase will come into effect on your first payment **after** your child's sixth birthday.

### **14. Are there any other reasons why I would need to reapply?**

**YES.** If a payment is returned to Easter Seals Ontario, and we have not heard from you for a change of address or you have not responded to a review for over one year, the grant will be cancelled and you will need to reapply.

### **15. My child is very young . How do I have the payments sent to me?**

You must indicate on the application, who the payments are to be made to. If there is a change in who is to receive the payment, a change of payee form must be obtained from the program, filled out and returned before any changes can be made.

### **16. I am not a parent but am acting as the applicant's agent. How can I have the payments made out to me?**

Agents must fill out the application and attach proof of guardianship, power of attorney, etc. Copies of documents are acceptable. On receipt of this information the payment will be sent to the appropriate person/agency.

### **17. My child is older but still wets/soils the bed. Will the Incontinence Grant Program pay for incontinence supplies?**

**No.** There are several types of incontinence. Children and youth eligible for funding have a type of incontinence that cannot be treated.

Persons with enuresis (bedwetting), encopresis (stool soiling) or stress incontinence are not eligible to receive a grant, as these conditions can usually be resolved with appropriate medical and/or rehabilitative interventions. The following describes these types:

Enuresis (bedwetting) usually occurs at night or during sleep after an age at which urinary control should have been achieved.

Encopresis (stool soiling) is a complication of constipation. There are many ways to resolve these problems and you should consult with your doctor. Stress incontinence is a form of urinary incontinence that can occur unexpectedly during physical exertion such as coughing, laughing or lifting. This condition usually occurs in the older population.

### **18. Where should I buy my incontinence supplies?**

You can buy your supplies from any store in Ontario that sells these products.

### **19. Will my insurance cover any costs?**

If you have private medical coverage some insurance plans will reimburse your additional costs, you will need to call them to check your plan coverage. Be sure to keep all Incontinence Supplies Grant Program correspondence as your insurance company may ask you to send them information about monies received.

### **20. What if my application is incomplete?**

Your application must be complete for the grant to be approved. If the application is not complete it will be returned to you with a letter explaining what is required to complete it.

### **21. What if my payment is returned to Easter Seals Ontario?**

If your payment is returned due to a change in address and you have not notified Easter Seals Ontario for one year the grant will be cancelled. You must re-apply for funding and be approved prior to any payments being issued. No missed payments will be issued for the missed year. If you notify Easter Seals Ontario, Incontinence Grant Program within the year, you will be reinstated and past missed payments will be issued.

### **22. Can I fax my application in?**

**No.** The Incontinence Supplies Grant Program will not accept faxed copies or photocopies of the application.

### **23. What if I have more questions?**

You can call the Incontinence Grant Program for Children & Youth with Disabilities at Easter Seals Ontario at these numbers: Toronto (416) 421-8377 ext. 314 or Toll free: 1-800-668-6252 ext. 314



Helping Kids with Physical Disabilities Succeed

### Incontinence Supplies Grant Program Application

Please print in pen

**FAXES or PHOTOCOPIES** of this form will not be accepted.

It is an offense to knowingly provide incorrect information on this application.

**Please Note: Program funding is a contribution towards the cost of supplies and may not cover all costs.**

#### SECTION 1

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male  Female   
(Last name) (First Name) (year/month/day)

Address: \_\_\_\_\_  
(Apt #, Street Address)

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Number (work/cell): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

- Does your child receive Assistance for Children with Severe Disabilities (ACSD): \_\_\_\_\_  Yes  No
- Do you have another child enrolled in the program: \_\_\_\_\_  Yes  No

\_\_\_\_\_  
(Name/s of children)

**Payment to be made to:**

Name of Payee: \_\_\_\_\_  
(Please Print)

Address of Payee: \_\_\_\_\_  
(Apt #, Street, City, Postal Code)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
(year/month/day) (Agents/Legal Guardians please see below)

**Agents/ Legal Guardians:**

o Documents Enclosed: If a child is a crown ward, or placed in a group home, or if there is a change in parental custody, please provide copies of legal documentation outlining legal guardianship. **(Failure to provide appropriate documentation i.e. Court orders for Crown Wards, will result in delay in processing of the application)**

- I certify that I or my child am/is not a resident of an acute or chronic care hospital, Schedule I or III Ministry of Community and Social Services (MCSS) residential facility, or Schedule II Ministry of Health and Long Term Care (MOHLTC) facility.
- I certify that the information in this application is true, correct and complete to the best of my knowledge. I authorize the release of information collected under sections 4, 10, 11, 17, 29 and 45 of the Health Insurance Act. R.S.O. 1990, C.H. 6 in order to verify that I am eligible for health coverage
- I understand the information on this form is subject to audit by Easter Seals Ontario.
- **\*I have fully read the application guidelines and understand that it is my responsibility to keep all receipts for incontinence supplies purchased, as I will be required to participate in audits while enrolled in the program.**

**\*Parent's/Applicant's/Agent's Please initial:** \_\_\_\_\_

Parent's/Applicant's/Agent's signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_  
(year/month/day)

Please review the form before sending in to make sure all information is provided. **Please note: the grant begins after the application is approved; the program is unable to provide retroactive payments.** If any information is missing, the application will be returned to you for completion resulting in delay in processing the application. **Please Note:** the continuation of the grant is conditional upon Easter Seals Ontario continuing to operate the Incontinence Supplies Grant Program for Children and Youth with Disabilities and upon funding for the grant continuing to be made by Her Majesty the Queen the Right of the Province of Ontario to Easter Seals Ontario.

**SECTION 2**

**Your Doctor or Nurse Practitioner must fill in this section**

**Please note:** Applicants must have a **chronic disability** resulting in irreversible incontinence or retention problems lasting longer than six months. Children or youth with night time **bed wetting (nocturnal enuresis)**, or **stress incontinence** are **not eligible** to receive a grant (see #18 of the attached application guidelines). Please attach any available medical notes relating child's diagnosis to his/her incontinence.

Chronic Disability: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Surgical Procedure & Date (if applicable): \_\_\_\_\_

**Bladder:**

- Incontinent: - - - - - → Totally:  Frequently:  Rarely:   
(no control) (some control) (occasional loss of control)
- Incontinent during: - - - - - → Day & Night:  Night Only:
- Is the applicant on a toileting routine? - - - - - → Yes:  No:
- Can the applicant achieve bladder control? - - - → Yes:  No:  Unknown:

**Bowel:**

- Incontinent: - - - - - → Totally:  Frequently:  Rarely:   
(no control) (some control) (occasional loss of control)
- Incontinent during: - - - - - → Day & Night:  Night Only:
- Is the applicant on a toileting routine? - - - - - → Yes:  No:
- Can the applicant achieve bowel control? - - - - - → Yes:  No:  Unknown:

**Check Level A OR Level B and indicate product type:**

- |   |           |   |
|---|-----------|---|
| <input type="checkbox"/> <b>Grant level A (\$400/yr)</b><br>Product Type:<br><input type="radio"/> Diapers (3-5 years)<br><input type="radio"/> Intermittent/Foley catheters<br><input type="radio"/> Reusable cloth diapers/liners | <b>OR</b> | <input type="checkbox"/> <b>Grant level B (\$900/yr)</b><br>Product Type:<br><input type="radio"/> Diapers (6 to 18 years)<br><input type="radio"/> Male external catheters |
|---|-----------|---|

Applicants may be eligible to receive **either** Grant Level A or Grant Level B. Persons may also be eligible for an additional grant if they use supplies required for ongoing bowel routines. Please indicate below whether or not the applicant requires these supplies.

- Grant Level C (\$200/yr):**  
**Bowel Management:** (3-18 years) (includes enema administration kits, tubing, glycerin suppositories).  
 It **DOES NOT INCLUDE** Fleet enemas or any medications (i.e. stool softeners, laxatives etc)  
 Used  Not Used

**Please indicate products, amount and frequency of use:** \_\_\_\_\_

I certify that the above named child/youth requires the personal use of incontinence supplies on an ongoing basis.

Physician or Nurse Practitioner: \_\_\_\_\_  
(Please Print Name)

Physician's College (CPSO) Certificate No: \_\_\_\_\_ or NP Verification No: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Year/month /day



Please complete the banking information below, should you wish to receive this grant as a direct deposit:

Account Holder's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No: \_\_\_\_\_

\_\_\_\_\_ E-mail: \_\_\_\_\_

Child's name: \_\_\_\_\_

Child's Health Card No: \_\_\_\_\_ Version Code: \_\_\_\_\_

Please attach a blank cheque marked "void".

ATTACH A VOIDED CHEQUE HERE

If unable to provide a voided cheque, please complete the following information:

Transit # \_\_\_\_\_ (5 digits) Bank Branch #: \_\_\_\_\_ (3 digits) Account #: \_\_\_\_\_

Please enter all of the numbers as printed on the bottom of your cheque:

\_\_\_\_\_

**AUTHORIZATION:**

I hereby authorize the above depositor to deposit directly to the account indicated above.

This Authorization will be in force until notice in writing is given to stop the direct deposit.

Signature: \_\_\_\_\_ Date Authorized: \_\_\_\_\_  
(year/month/date)

**Return form to the Program Coordinator at:**

**Easter Seals Ontario, I.G. Program**  
**One Concorde Gate, Suite 700**  
**Toronto, Ont. M3C 3N6**  
**(416) 421-8377 x 314**  
**Toll Free 1-800-668-6252**  
[www.easterseals.org](http://www.easterseals.org)