



Helping Kids with Physical Disabilities Succeed

Incontinence Supplies Grant Program Level B Application

FOR OFFICE USE ONLY

Date Rec'd: _____ Date Processed: _____ Date Approved: _____
Cycle: _____ Level: _____ Review Date: _____ Approved by: _____

IMPORTANT NOTES: This application is for clients already actively enrolled in the program and who would like to apply for the increase to Level B funding. If you are a new client or were a previously registered family and are no longer receiving grant funding you must submit a new application. Applications take 4-6 weeks to process.

Please print clearly. Applications can be sent in my mail, fax or e-mail. 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

Incontinence Grant #: _____
Child's Last Name: _____ Child's First Name: _____
Date of Birth (yyyy/mm/dd): _____ Sex: Male Female
Child's Health Card #: _____ Version Code: _____

Please complete to ensure that we have the most up to date information on file:

Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone #: (_____) _____ Alternate # (work/cell): (_____) _____
Email: _____

Payment Information

Once approved your payments will continue to be sent to you on your scheduled payment cycle either by mail or by direct deposit. If you are not receiving direct deposit but would like to, please contact the program coordinator for a direct deposit form.

Important: All original payee(s) must sign this application. If there are changes to the payee(s) you must contact the program coordinator and complete a Change of Payee form. Due to client confidentiality, information will only be released to the payee(s) listed on the application.

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Jan: _____ Feb: _____ Mar: _____ Apr: _____
May: _____ Jun: _____ Jul: _____ Aug: _____
Sep: _____ Oct: _____ Nov: _____ Dec: _____

SECTION 2

Please indicate product type:

Grant Level B (\$900/yr) → Product Type: Diapers (6-18 years) External Catheters/drainage bags

If you are applying for Grant Level C for Bowel Management Supplies, you must submit a new application and have it completed by a Medical Physician or Nurse Practitioner.

<u>Bladder: (complete all areas)</u>			
Incontinent:	<input type="checkbox"/> Totally (no control)	<input type="checkbox"/> Frequently (some control)	<input type="checkbox"/> Rarely (occasional loss of control)
Incontinent during:	<input type="checkbox"/> Day & Night	<input type="checkbox"/> Night Only	
Is the applicant on a toileting routine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Will your child achieve bladder control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<u>Bowel: (complete all areas)</u>			
Incontinent:	<input type="checkbox"/> Totally (no control)	<input type="checkbox"/> Frequently (some control)	<input type="checkbox"/> Rarely (occasional loss of control)
Incontinent during:	<input type="checkbox"/> Day & Night	<input type="checkbox"/> Night Only	
Is the applicant on a toileting routine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Will your child achieve bowel control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Breakdown of typical monthly incontinence supplies (diapers, pull ups, catheters, etc.):

Product(s) used: _____ Amount used per day: _____

Cost per package: _____ Estimated monthly costs: _____

I have submitted 4 months of current receipts with the application form.

- If you have not kept or misplaced your receipts, collect your receipts for the next 4 months and submit them at that time.
- Receipts can be emailed or faxed as long as they are legible and are the complete receipt, altered/folded receipts will not be accepted. Original receipts can be returned upon request. Receipts not returned are destroyed after they are reviewed.
- **NOT COVERED under the grant: Gloves, wipes, creams, prescriptions (including enema), clothing/linens, laundry detergent and pads for menstrual period.**

Parent/Legal Guardian #1:

Name (Print): _____ Signature: _____ Date (yy/mm/dd): ___/___/___

Parent/Legal Guardian #2:

Name (Print): _____ Signature: _____ Date (yy/mm/dd): ___/___/___

Please review the form before sending it 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 a delay in processing the application.

Please send completed form and receipts to: Program Coordinator

Mail: Easter Seals Ontario, I.G. Program, 700-1 Concorde Gate, Toronto, ON, M3C 3N6

Fax: 416-696-1035

Email: igprogramcoordinator@easterseals.org