



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. Applications must include a minimum of 4 months current receipts.
- Please print clearly. Applications that are not clear or incomplete will be returned.
- Applications take 4-6 weeks to process.
- Receipts can be mailed (original receipts can be returned upon request; receipts not returned are destroyed).
- Receipts can also be sent by email or fax (must be legible and the complete receipt including the date of purchase, altered/folded receipts are not accepted).
- 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.
- It is an offense to knowingly provide incorrect information on this application.

SECTION 1

Incontinence Grant #: _____

Child's Last Name: _____ Child's First Name: _____

Date of Birth (yyyy/mm/dd): _____ Gender: _____

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: _____

Phone #: (_____) _____ Alternate # (work/cell): (_____) _____

E-mail: _____

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 accountant 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 file.

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

Please indicate product type:

- Grant Level B (\$900/yr)** → **Product Type:** Diapers, Pull Ups, Attends, Swimmers (6-18 years)
 Catheters/drainage bags

Bladder: (complete all areas)			
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
Bowel: (complete all areas)			
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 _____ night: _____
Cost per package: _____ Estimated monthly costs: _____

I have submitted 4 months of current receipts with the application form. Applications without 4 months of current receipts will not be processed. **Please initial:** _____

- If you have not kept or misplaced your receipts, collect your receipts for the next 4 months and submit them at that time.
- Original receipts can be returned upon request. Receipts not returned are destroyed after they are reviewed. Receipts that are e-mailed or faxed must be legible and the complete receipt showing, altered/folded receipts will not be accepted.
- **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 note: the grant begins after the application is approved; the program is unable to provide retroactive payments. Please review the form before sending it in to make sure all information is complete. 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