

EASTER SEALS ONTARIO: REGISTRATION APPLICATION



Helping Kids with Physical Disabilities Succeed

FOR OFFICE USE ONLY:

ESCR #: _____

Reviewed by: _____ Diagnosis Group: _____

Meets ES Eligibility Criteria: Yes No Diagnosis Primary: _____

Diagnosis: _____

IMPORTANT – PLEASE READ:

Please print clearly and complete all sections of the registration form in ink.

Section Four must be completed by the child’s Occupational Therapist (OT) or Physiotherapist (PT). In order to be eligible for registration the child must be a legal resident of Ontario, have a valid Ontario Health Card, who is under the age of 19 years, and must have a permanent **physical disability** that restricts their independent mobility and results in the use of a primary mobility device such as long term orthotics, wheelchair or walker. Eligibility does **not** extend to children that are not using a primary mobility device.

If you are receiving funding from the Incontinence Supplies Grant Program you are not automatically a client of Easter Seals Ontario. The Incontinence Supplies Grant Program is administered on behalf of the Ministry of Health and Long-Term Care and is a completely independent program with separate eligibility criteria and application form.

If your child meets Easter Seals Ontario’s eligibility criteria, an information package will be sent to you. If your child does not meet the criteria, you will be notified with a letter. **Please allow 4 weeks to process your application. Once your child is registered with Easter Seals Ontario they will be a client until their 19th birthday, at which time they are discharged.**

SECTION ONE: DEMOGRAPHIC INFORMATION

(TO BE COMPLETED BY PARENT/GUARDIAN)

CHILD’S INFORMATION:

Last Name: _____ First Name: _____

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

Address: _____

City: _____ Postal Code: _____ Home #: _____

OTHER INFORMATION:

Main language spoken at home: _____ Interpreter needed? No Yes

How did you find out about Easter Seals? _____

Does your child live in a: Family Home Group Home Other: _____

Is the child a Crown Ward of Children’s Aid Society? No Yes

IF THE CHILD IS A CROWN WARD THEN THEY ARE NOT ELIGIBLE FOR FUNDING FOR FINANCIAL ASSISTANCE FOR EQUIPMENT. THEY WILL RECEIVE RESOURCE INFORMATION AND ARE WELCOME TO ATTEND AN EASTER SEALS CAMP IF THEY MEET THE CAMP ELIGIBILITY CRITERIA AND PAY FULL FEES.

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PARENT / LEGAL GUARDIAN(S) INFORMATION:	
Guardian #1 – Relationship to child: _____	
Last Name: _____	First Name: _____
Employer: _____	Cell #: (_____) _____
Email: _____	
Seals will send out information when there is exciting events in your area, resource information and our e-newsletter.	
Guardian #2 – Relationship to child: _____	
Last Name: _____	First Name: _____
Employer: _____	Cell #: (_____) _____
PARENT / LEGAL GUARDIAN(S) ADDRESS – <u>ONLY</u> IF DIFFERENT FROM ABOVE:	
Address: _____	
City: _____	Postal Code: _____

FOR STATISTICAL PURPOSES <u>ONLY</u> , PLEASE INDICATE YOUR TOTAL HOUSEHOLD INCOME:				
<input type="checkbox"/> \$0-\$20,000	<input type="checkbox"/> \$20,001-\$40,000	<input type="checkbox"/> \$40,001-\$60,000	<input type="checkbox"/> \$60,001-\$80,000	<input type="checkbox"/> \$80,001-\$100,000
<input type="checkbox"/> \$100,001-\$120,000	<input type="checkbox"/> \$120,001-\$140,000	<input type="checkbox"/> \$140,001-\$160,000	<input type="checkbox"/> \$160,001-\$180,000	<input type="checkbox"/> \$180,001-over

SECTION TWO: SUPPORT AND ASSISTANCE

(TO BE COMPLETED BY PARENT/GUARDIAN)

Please answer all questions in this section as they will enable Easter Seals Ontario to direct you to the appropriate source of support.

DOES YOUR CHILD RECEIVE/ HAVE ANY OF THESE SERVICES?			
A valid Ontario Health Card?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Receiving Interim Federal Health?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Special Services at Home (SSAH) Funding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Social Assistance (e.g. Ontario Works)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Assistance for Children with Severe Disabilities (ACSD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Employer Extended Health Care Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes
OTHER SOURCES OF ASSISTANCE YOU RECEIVE (e.g. OFCP, MUSCULAR DYSTROPHY CANADA, ETC):			
WHAT TREATMENT CENTRE AND/OR HOSPITAL(S) DOES YOUR CHILD GO TO - PLEASE LIST:			

SECTION THREE: AUTHORIZATION

(TO BE COMPLETED BY PARENT/GUARDIAN)

<p>I UNDERSTAND EASTER SEALS ONTARIO MAY CARRY OUT INQUIRIES FOR THE PURPOSE OF CONFIRMING OR CLARIFYING THE INFORMATION SUBMITTED, PROCESSING THE APPLICATION, ADDRESSING AN APPEAL, OR WITH ANY OTHER AGENCY LISTED ON THIS APPLICATION FORM. I FURTHER UNDERSTAND AND AGREE THAT THESE INQUIRES MAY REQUIRE EXCHANGE OF INFORMATION THAT MAY TAKE THE FORM OF ELECTRONIC DATA EXCHANGE.</p> <p>I UNDERSTAND THAT THE INFORMATION PROVIDED WILL ONLY BE USED BY EASTER SEALS ONTARIO TO ASCERTAIN ELIGIBILITY FOR REGISTRATION AND TO SUPPORT THE NEEDS OF MY CHILD. I CERTIFY THAT ALL THE INFORMATION PROVIDED ON THE APPLICATION FORM IS TRUE.</p>	
<p>_____</p> <p style="text-align: center;">Parent/Legal Guardian(s) Signature</p>	<p>_____</p> <p style="text-align: center;">Date</p>

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SECTION FOUR: CHILD'S DISABILITY (MUST BE COMPLETED BY OT OR PT)



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This section must be completed by the client's Occupational Therapist OR Physiotherapist, licensed to practice in Ontario. Please complete all questions. If the Registration is not complete it will be returned and will not be processed.

Easter Seals Ontario is a charity that provides assistance to children and youth that have a *permanent physical disability that results in the need to use a mobility device as a primary device.* Easter Seals Ontario reserves the right to determine if an applicant meets the eligibility criteria.

Eligibility criteria requires that the child or youth will need to use a long-term mobility device as a primary device, such as LONG TERM orthotics, walker or wheelchair.

The child would not be eligible if his/her ADP funded stroller/wheelchair is being used only for long distance, fatigue or lack of endurance.

The child would not be eligible if his/her stroller or wheelchair has been prescribed and approved by the Assistive Devices Program for safety only.

If the child is under the age of 6 and it is not yet known if they will require mobility equipment, please wait to register until an assessment has been completed prescribing the child a long-term mobility device.

DIAGNOSIS (PLEASE BE SPECIFIC):	
<hr/> <hr/>	
DESCRIPTION OF DISABILITY – describe how it affects daily living/mobility. Focus on impact on the child's mobility. Feel free to include a current OT/PT assessment that has been completed within the last 3 months.	
<hr/> <hr/>	
OVERVIEW OF GROSS MOTOR FUNCTIONS – CAN THE CHILD:	
Roll? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	Sit? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
Stand? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	Walk? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
Walk with Assistance: How far independently? _____	
Type of assistance: Hand Holding? <input type="checkbox"/> No <input type="checkbox"/> Yes Equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes	Holding on to objects? <input type="checkbox"/> No <input type="checkbox"/> Yes
Climb stairs? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	ADL's? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
IF APPLICABLE PLEASE SELECT THE GROSS MOTOR FUNCTION LEVEL?	
<input type="checkbox"/> Level I	<input type="checkbox"/> Level II
<input type="checkbox"/> Level III	<input type="checkbox"/> Level IV
<input type="checkbox"/> Level V	

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SECTION FOUR (CONT'D): CHILD'S DISABILITY (MUST BE COMPLETED BY OT OR PT)

IF THE CHILD IS BELOW THE AGE 6, PLEASE COMPLETE THIS SECTION:

Does the child walk in his/her immediate environment at home? No Yes With assistance
If with assistance please give a detailed description: _____

Does the child walk in his/her immediate environment at school? No Yes With assistance
If with assistance please give a detailed description: _____

Does the child have orthotics? No Yes What type of orthotics? _____
If yes, are they ADP funded? No Yes Will they be required long term? No Yes Unable to determine

Does the child have a stroller? No Yes
If yes, is it ADP funded? No Yes Will it be required long term? No Yes Unable to determine

Will the child need long term mobility equipment in the future? No Yes Unable to determine
If yes will equipment be prescribed:
 within 6 months 1 to 2 years 5 years Longer

******IF YOU ARE UNABLE TO DETERMINE IF THE CHILD IS GOING TO NEED MOBILITY EQUIPMENT ON A LONG TERM BASIS THEN THE REGISTRATION REQUEST SHOULD NOT BE COMPLETED AT THIS TIME.******

FOR ALL AGES - IS THE CHILD:

Incontinent: No Yes *
*If yes, please visit www.easterseals.org the Incontinence Supplies Grant Program to download the guidelines and application form. **The Incontinence Supplies Grant Program is administered on behalf of the Ministry of Health and Long-Term Care and is a completely independent program with separate eligibility criteria and application form.**

DOES THE CHILD USE THE FOLLOWING EQUIPMENT?

Mobility equipment that was prescribed outside of Ontario? No Yes
If yes: From where? _____

Stroller
 No Yes – if yes, is it ADP funded? No Yes
 Being assessed- if selected, will it meet ADP criteria? No Yes
Being used for all mobility outside of the home? No Yes
Being used for long distance only? No Yes
Being used for safety so child is not able to run away? No Yes
Being used for transportation to school? No Yes
Being used within the school? No Yes
Is this the child's first ADP funded stroller? No Yes

Manual Wheelchair
 No Yes – if yes, is it ADP funded? No Yes
 Being assessed- if selected, will it meet ADP criteria? No Yes
Can child propel own chair? No Yes
Is this the child's first ADP funded wheelchair? No Yes

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SECTION FOUR (CONT'D): CHILD'S DISABILITY (MUST BE COMPLETED BY OT OR PT)

Power Wheelchair	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes Is this the child's first ADP funded power wheelchair? <input type="checkbox"/> No <input type="checkbox"/> Yes
Walker	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Stander	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Braces (AFO's/KAFO's)	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Bath/Shower Aids	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed
Communication Device	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
DOES THE CHILD HAVE THE FOLLOWING? CHECK (✓) ALL THAT APPLY	
<input type="checkbox"/> Porch Lift <input type="checkbox"/> Van Lift <input type="checkbox"/> Track Lift <input type="checkbox"/> Stair Lift <input type="checkbox"/> Portable Lift <input type="checkbox"/> Ramp	

THERAPIST INFORMATION:	
Name: _____	<input type="checkbox"/> OT <input type="checkbox"/> PT – Registration #: _____
Organization (e.g. CCAC, Treatment Centre, etc): _____	
Phone #: (_____) _____	E-mail: _____
Date (yyyy/mm/dd): _____ / _____ / _____	Signature: _____

COMPLETED APPLICATIONS CAN BE SENT VIA:

Mail: Registration, Easter Seals Ontario, 700-1 Concorde Gate, Toronto, Ontario, M3C 3N6

Fax: 416.696.1035 (please send to the attention of Registration Provincial Services)

E-mail: services@easterseals.org

Please note that it is the parent/guardian(s) responsibility to follow up with Easter Seals Ontario to ensure the application has been received. If you have any questions about the application, please do not hesitate to contact Provincial Services at 416.421.8146, toll free at 1.866.630.3336 or email services@easterseals.org.

If required, and upon request, Easter Seals Ontario will provide or arrange for the provision of this form in an accessible format and/or provide communication supports related to this form for persons with disabilities.