Helping Kids with Physical Disabilities Succeed

Incontinence Supplies Grant Program Application

FOR OFFICE USE ONLY

Date Received: ____________________ Date Processed: ____________________ Date Approved: ____________________

Cycle: ___________ Level: __________ Review Date: ______________________ Approved by: ______________________

IMPORTANT NOTES:

- **Please print clearly. Applications that are not clear will be returned. Applications take 4-6 weeks to process.**
- **Applications can be sent in by mail, fax or e-mail.**
- **Images must be clear, please keep a copy of your original application. Unclear or altered applications may require originals to be sent in by mail.**
- **Please review the Program Guidelines prior to filling out this application.**
- **If you were previously registered and are no longer receiving the grant please include 4 months of current receipts with the application.**
- **If you are already registered and are applying for the grant increase please complete the Level B application found on the Easter Seals website at www.easterseals.org.**

SECTION 1

Child's Heath Card #: ____ **Version Code:** ______________________

Child's Last Name: ____________________________________ Child's First Name: ____________________________________

Date of Birth: year _________ / month ______ / day ______ Sex: ☐ Male ☐ Female

Address: ____

City: ____________________________ Province: _________________________ Postal Code: _______________________

Phone #: (______) __________________________________ Alternate # (work/cell): (______) _______________________

Email: ____

Do you prefer Easter Seals Ontario to contact you by email in regards to this application? ☐ Yes ☐ No

Does your child receive Assistance for Children with Severe Disabilities (ACSD)? ☐ Yes ☐ No

Do you have another child enrolled in the Incontinence Supplies Grant Program? ☐ Yes ☐ No

If Yes, please list their name(s): ____

Interpreter required for parent/guardian: ☐ Yes ☐ No Language:

____

☐ I give my permission for the Incontinence Supplies Grant Program Employees to contact the following individual/agency and share information regarding my child's file. I understand I can revoke this consent at any time by contacting Easter Seals Ontario

☐ Individual – Print Name: __________________ Relationship: ______________ Phone #: (____) _________________

☐ Agency – Print Name: ____________________ Contact Name: ____________ Phone #: (____) _________________

SECTION 2

	Parent/Guardian(s) Initial(s)
☐ **I/We am/are the Parent(s)/Legal Guardian(s) of the child. Information can only be shared with the Parent(s)/Legal Guardian(s) and/or payees as listed on the file.** *Legal Guardian(s): 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. **Legal Documents Enclosed:** ☐ Yes	_____ _____
☐ I/We certify that I/we or my/our 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/We certify that the information in this application is true, correct and complete to the best of my knowledge. I/we 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.	_____ _____

SECTION 3 – DIAPERS/CATHETERS

Bladder: (complete all areas)

Incontinent:	☐ Totally (**no** control)	☐ Frequently (**some** control)	☐ Rarely (**occasional** loss of control)
Incontinent during:	☐ Day & Night	☐ Night Only	
Is the applicant on a toileting routine?	☐ Yes	☐ No	
Will your child achieve bladder control?	☐ Yes	☐ No	☐ Unknown

Bowel: (complete all areas)

Incontinent:	☐ Totally (**no** control)	☐ Frequently (**some** control)	☐ Rarely (**occasional** loss of control)
Incontinent during:	☐ Day & Night	☐ Night Only	
Is the applicant on a toileting routine?	☐ Yes	☐ No	
Will your child achieve bowel control?	☐ Yes	☐ No	☐ Unknown

Breakdown of typical monthly incontinence supplies (diapers, pull ups, catheters etc.) The grant **does not cover** gloves, wipes, creams, clothing, laundry items or pads for menstrual period**:**

Product(s) used: Diapers/ Pull-ups/ Swimmers/ Attends/ Liners — Amount used per: day _________ / night _________

Catheters/ Drainage Bags — Amount used per: day _________ / night _________

Average Cost per package: _____________________ Estimated monthly costs: ___________________________

	Parent/Guardian(s) Initial(s)
☐ I/We am/are aware that it is my/our responsibility to keep receipts for the incontinence supplies purchased. I/we will be required to participate in reviews while enrolled in the program.	_____ _____
☐ I/We acknowledge that the above information is an accurate reflection of my child's current incontinence needs.	_____ _____

TO BE COMPLETED BY YOUR DOCTOR OR NURSE PRACTITIONER

If information is incomplete, the form will be returned to the parent/legal guardian.

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 #17 of the attached application guidelines). Please attach any available medical notes relating the child's diagnosis to his/her incontinence.

Chronic Disability: ____

Secondary Diagnosis: ____

Surgical Procedure & Date (if applicable): ____

☐ **I certify that the above named child/youth has irreversible incontinence lasting longer than 6 months and requires the use of personal incontinence supplies for day and night use on an ongoing basis.**

Name of Physician or Nurse Practitioner (Please Print): ____

Physician's College (CPSO) Certificate #: ________________________ or NP Verification #: ________________________________

Address: ____ Phone #: (_____) _________________________________

Date: year _______ / month _____ / day _____ Signature: ____

SECTION 4 – BOWEL MANAGEMENT

Please proceed to payee information if not applicable

Applicants may also be eligible for an additional grant if they use specific supplies required for ongoing bowel management. The grant **does not cover** any medicated items such as fleet enemas, PEG, stool softeners, laxatives etc).

Product(s) used: ☐ Cecostomy — Amount used per week: _____________

☐ MACE — Amount used per week: _____________

☐ Glycerin Suppositories/Liquid — Amount used per week: _____________

☐ Other – please specify: ___________________________ — Amount used per week: _____________

Cost per item: ____ — Estimated monthly costs: ____________

	Parent/Guardian(s) Initial(s)
☐ I/We am/are aware that it is my/our responsibility to keep receipts for the incontinence supplies purchased. I/we will be required to participate in reviews while enrolled in the program.	_____ _____
☐ I/We acknowledge that the above information is an accurate reflection of my child's current incontinence needs.	_____ _____

*****TO BE COMPLETED BY YOUR DOCTOR OR NURSE PRACTITIONER*****

If information is incomplete, the form will be returned to the parent/legal guardian.

Chronic Disability: ____

Secondary Diagnosis: ____

Surgical Procedure & Date (if applicable): ____

☐ **I certify that the above named child/youth requires the above bowel management supplies on an ongoing basis.**

Name of Physician or Nurse Practitioner (Please Print): ____

Physician's College (CPSO) Certificate #: ________________________ or NP Verification #: _______________________________

Address: ____ Phone #: (_____) _________________________________

Date: year _______ / month _____ / day _____ Signature: ____

SECTION 5 – PAYEE INFORMATION

Payment Information

Parents/Legal Guardian(s) can direct payments to themselves or assign to another party who has current care of the child. Due to client confidentiality, <u>information will only be released to the Parent(s)/Legal Guardian(s) and/or Payee(s) listed on the application</u> unless permission has been given by the parent(s)/Legal Guardian(s).

Payments are to be made to (please check one):

☐ Parent(s)/Legal Guardian(s)
☐ Relative
☐ Agency/Group Home

Print Name of Payee #1: ____ Relationship to child: _______________________

Print Name of Payee #2: ____ Relationship to child: _______________________

Address: ____

City: ______________________________ Province: __________________________ Postal Code: ________________________

Email: ____

Do you prefer Easter Seals Ontario to contact you by email in regards to this application? ☐ Yes ☐ No

Payee Signature #1: ____ Date: year ________ / month _____ / day _____

Payee Signature #2: ____ Date: year ________ / month _____ / day _____

*Please fill out a direct deposit form if you wish the grant to be directly deposited into your bank account, otherwise cheques will be mailed.

SECTION 6 – AUTHORIZATION (must be signed by parent(s)/Legal Guardian(s)).

Please review the form before sending it in to make sure all information is provided.

Please note: Grants are made in 2 payments 6 months apart, the grant begins after the application is approved and it is for the next 6 months of incontinence purchases; 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 condition up 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.

It is an offense to knowingly provide incorrect information on this application. Program funding is a contribution towards the cost of supplies and may not cover all costs. Misuse of funds is reportable to the Ministry of Health and Long Term Care.

	Parent/Guardian(s) Initial(s)
☐ I/We certify that the information on this application is true, correct and complete to the best of my/our knowledge.	_____ _____

Parent/Legal Guardian – Print Name: _________________________________ Relationship to child: _______________________

Parent/Legal Guardian Signature: ____________________________________ Date: year ________ / month _____ / day _____

Parent/Legal Guardian – Print Name: _________________________________ Relationship to child: _______________________

Parent/Legal Guardian Signature: ____________________________________ Date: year ________ / month _____ / day _____

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Incontinence Supplies Grant Program
Direct Deposit OPTION

SECTION 7

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

Account Holder's Name: ____

Address: ____

City: ______________________ Province: ____________________ Postal Code: __________________

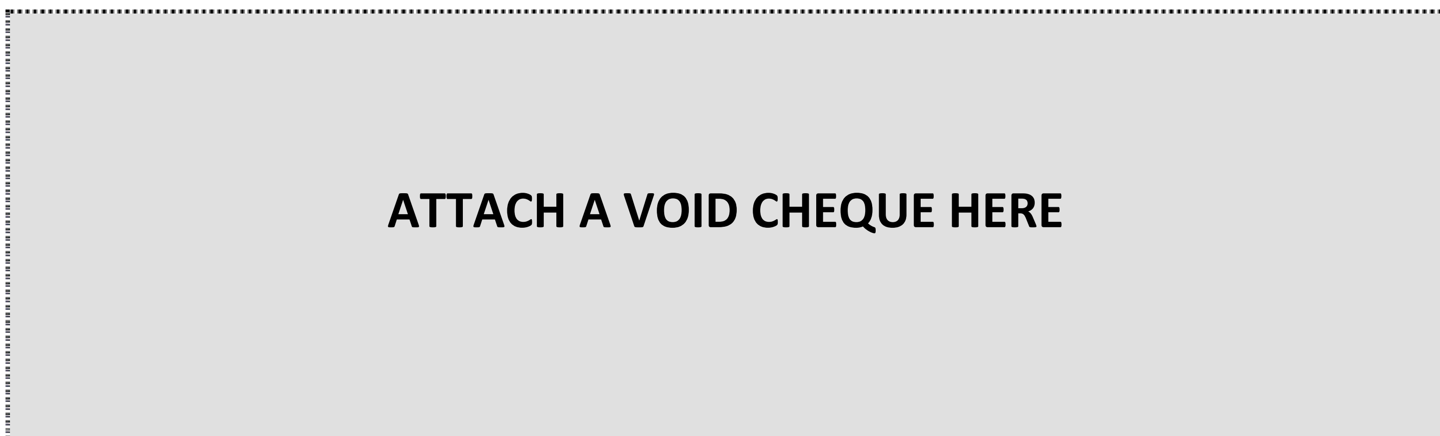
Telephone #: (_____) ______________________ Alternative # (work/cell): (_____) __________________

E-mail: ____

Child's name: ____

Child's Health Card #: ________________________________ Version Code: ________________

Please attach a blank cheque marked "void".



ATTACH A VOID CHEQUE HERE

If unable to attach a void cheque, please complete the following information (Please note that incorrect information could result in your cheque being deposited into a wrong account):

Transit # (5 digits): ______________ Bank Branch # (3 digits): __________ Account #: ________________

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

AUTHORIZATION

I hereby authorize the above depositor to deposit to the account indicated above. This authorization will be in force until notice in writing is given to stop the direct deposit.

Parent/Legal Guardian – Print Name: ________________________ Relationship to child: ________________

Parent/Legal Guardian Signature: __________________________ Date: year ________ / month _____ / day _____

Completed applications can be sent via:

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

Fax: 416-696-1035 *send attention I.G. Program*

E-mail: igprogramcoordinator@easterseals.org

For frequently asked questions please visit:
www.easterseals.org
Or contact:
Program Coordinator
(416) 421-8377 x 314
Toll Free 1-800-668-6252 x 314