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 review the Program Guidelines available at easterseals.org prior to filling out this application to ensure your child is eligible.**
- **Please print neatly. Applications that are not clear or incomplete are returned.**
- **Applications take 4-6 weeks to process.**
- **Applications can be sent in by mail, fax or e-mail.**
- **If sent electronically, images must be clear. Please keep a copy of your original application, as you may be required to submit original by mail.**
- **If you were registered and are no longer receiving the grant please include 4 months of current receipts with the application.**
- **If you are currently registered and are applying for the grant increase please read the program guidelines and complete the Level B application found at easterseals.org.**

SECTION 1 Must provide a valid Ontario Health Card

Child's Heath Card #: _____ _____ **Version Code:** _____ **Expiry Date:** _____

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

Date of Birth: year _____ / month _____ / day _____ Gender: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Main #: (_____) _____ Alternate #: (_____) _____

Email: _____

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

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

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

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

CONSENT

If you have an individual (e.g. service worker/relative) or an agency supporting you and you want the program to be able to share information with them please provide their information below. This consent can be revoked at any time by contacting the program.

Individual - print name: _____ Relationship: _____ Phone #: (____) _____

Agency - print name: _____ Contact Name: _____ Phone #: (____) _____

SECTION 2 (Please read and initial each box)

	Parent/Guardian(s) Initial(s)
I/We am/are the Parent(s)/Legal Guardian(s) of the child. **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 e.g. Court orders for Crown Wards, will result in delay in processing of the application. **Legal Documents are 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 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 (All areas must be completed)

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)
The grant does NOT cover: wipes, gloves, creams, clothing, laundry items including bedding 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: _____

(Please read and initial each box)	**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 be between the ages of 3-18 years and have a **chronic disability** resulting in irreversible incontinence or retention problems lasting longer than six months. Exception: children under the age of 3 may apply if using catheters or have continual drainage e.g. Vesicostomy. Please see the program guidelines for more detailed information. Children or youth with night time **bed wetting (nocturnal enuresis),** or **stress incontinence** are **not eligible** to receive the grant. If required 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 child/youth has irreversible incontinence lasting longer than 6 months and requires the use of personal incontinence supplies throughout both the day and night 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 (Supplies only)

Please proceed to payee information if this section does <u>not</u> apply

Applicants may also be eligible for an additional grant if they use specific supplies required for ongoing bowel management.

The grant does <u>NOT</u> cover any medicated items such as:

- fleet enemas
- Polyethlene glycol (PEG)
- stool softeners and laxatives (e.g. Restorlax, Dulcolax)

The grant also does <u>NOT</u> cover items such as:

- gloves
- wipes
- creams
- laundry (bedding)

Product(s) used:	☐ Cecostomy	Amount used per week: _____
	☐ MACE	Amount used per week: _____
	☐ Peristeen Irrigation System	Amount used per week: _____
	☐ Glycerin Suppositories	Amount used per week: _____
	☐ Glycerin Liquid	Amount used per week: _____
	☐ Other – please specify _____	Amount used per week: _____
Cost per item:	_____	Estimated monthly costs: _____

(Please read and initial each box)	**Parent/Guardian(s) Initial(s)**
I/We am/are aware that it is my/our responsibility to keep receipts for the bowel management 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 child/youth requires the above outlined <u>bowel management supplies</u> 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 (Must be completed by person(s) who will be receiving the grant)

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, information will only be released to the Parent(s)/Legal Guardian(s) and/or Payee(s) listed on the application unless permission has been given by the parent(s)/Legal Guardian(s).

I am the/We are the:

☐ 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: _____

Main #: (_____) _____ Alternate #: (_____) _____

Email: _____

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.

(Please read and initial)	**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 _____

Easter Seals Ontario
Helping Kids with Physical Disabilities Succeed

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: _____

Main #: (_____) _____ Alternative # (_____) _____

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 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: igprogram@easterseals.org

For frequently asked questions, please visit:
www.easterseals.org
or contact:
Program Coordinator
(416) 510-5074