Easter Seals Ontario — 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 of diaper purchases.**
- **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 and include the date of purchase, altered/folded receipts are not accepted).
- Please print clearly. Applications that are not clear or incomplete will be returned.
- Applications take 4-6 weeks to process.
- **If you have more than 1 child registered on the program include the receipts for all children. Applications are assessed on the total expenses.**
- **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 Heath Card #: _____ **Version Code:** _____ **Expiry Date:** _____

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

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

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: _____

SECTION 2

Please indicate product type:

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

	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.):

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 sent electronically (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 enemas), 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: igprogram@easterseals.org