Easter Seals Ontario — Helping Kids with Physical Disabilities Succeed

INCONTINENCE GRANT (IG) - REVIEW FORM

If your child's file is currently "under review", you must complete, sign and return with receipts to continue as an active client for IG and/or to apply for the Top Up Program.

Dear Parent/Guardian,

Your child is registered to receive the Incontinence Supplies Grant Program funded through the Ministry of Health and administered by Easter Seals Ontario. All clients are required to update their information every one or two years to determine the funding level based on proof of purchases. The review process is a program requirement for you to continue to receive the grant/s.

STEP 1: **Please complete the following information:** (please print clearly)

Child's Full Name:	
Child's Date of Birth: dd/mm/yyyy	
IG Client# (if known):	
Primary Mailing Address:	
Primary Email:	

STEP 2: Provide an update on your child's current need for incontinence supplies.

Bladder: (complete all areas)

Incontinent:	❑ Totally (**no** control)	❑ Frequently (**some** control)	❑ Rarely (**occasional** loss of control)
Incontinent during:	❑ Day & Night	❑ Night Only	

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	

Breakdown of Typical monthly incontinence supplies

Product(s) used: _____ Amount used during day:_____ Night:_____ Cost per month:$_____
(diapers, pull-ups, swimmers etc.)

Catheters used: _____ Amount used during day:_____ Night:_____ Cost per month:$_____

Level C: Bowel Management Supplies (Cecostomy, MACE, Peristeen Irrigation System etc.)

Product(s) used: _____ Amount used per week:_____ Cost per month:$_____

STEP 3: Sign and return this form with receipts for the past 4 months. *Failure to send receipts or respond may result in your child being cancelled from the program.*

Note: Gloves, wipes, creams, prescriptions (including enemas), clothing/linens, laundry detergent and pads for menstrual period are not covered. Misuse of funds is reportable to the Ministry of Health.

❑ I have included the **4 months of current receipts** with this form.

Name (print): _____ _____ _____
Parent/Legal Guardian | Signature | Date (dd/mm/yyyy)

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