Helping Kids with Physical Disabilities Succeed

Incontinence Supplies Grant Program Application

IMPORTANT NOTES:

- Program guidelines, funding levels and answers to frequently asked questions; including how to complete an application are available at **services.easterseals.org**.
- All applications will be processed on a date received basis. All incomplete or unclear applications will delay processing times. Please read each section before completing.
- **If you are currently registered** and are applying for the grant increase do not fill out an application, please submit your last 4 months of current receipts to the program **with** a Level B form, available at services.easterseals.org.

Completed applications can be sent via:

- **Mail:** Easter Seals Ontario, Attention I.G. Program
  One Concorde Gate, Suite 700
  Toronto, ON M3C 3N6
- **Fax:** 416-696-1035
- **E-mail:** igprogram@easterseals.org

***Please keep a copy for your records**

PLEASE SELECT APPLICATION TYPE:

☐ New Application

☐ Re-Application (**If you were previously registered** and are no longer receiving the grant, please complete the application and include **4 months of current receipts**. You do not need to have the application re-signed by a Doctor or Nurse Practitioner).

SECTION 1: Must provide a valid Ontario Health Card (Print in ALL CAPS)

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

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

Date of Birth: month _____ / day _____/ year _____ Gender: ☐ Female ☐ Male ☐ Other: _____

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 TO SHARE INFORMATION

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

Individual (print name): _____ Relationship: _____ Phone #: (___)_____ Email: _____

Agency (print name): _____ Relationship: _____ Phone #: (___)_____ Email: _____

SECTION 2: (Please read. IT IS MANDATORY to have each box initialled.)	**Parent/Guardian(s) Initial(s)**
I/We am/are the Parent(s)/Legal Guardian(s) of the child. **Please note for 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 only If a child is a Crown Ward, or placed in a group home, or if there is a change in parental custody:** ☐ **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 (MOH) 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: (MANDATORY - all areas must be completed)

Funding levels for applications that meet the eligibility criteria are:

Level A ($400/year) Diapers/Catheters or **Level B** ($900/year) Diapers/Catheters;

- Applications requesting the higher funding level (Level B; $900/year) must be submitted with 4 months of current receipts
- **Or** apply to receive (Level A) without receipts. If approved, save 4 months of current receipts and submit with a Level B Increase form

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 (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 **Number used per: day _____ / night_____**

Catheters/ Drainage Bags **Number used per: day _____ / night _____**

Estimated monthly costs: $_____

(Please read. IT IS MANDATORY to have each box initialled.)	**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.	_____ _____

MUST BE COMPLETED BY YOUR DOCTOR OR NURSE PRACTITIONER WITHIN 6 MONTHS OF APPLYING

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 nighttime **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.

Primary Diagnosis (reason for incontinence) _____

Secondary to Chronic Disability/Condition _____

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: month _____ / day _____/ year _____ Signature: _____

SECTION 4 - BOWEL MANAGEMENT: ☐ Level C $500/year

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

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

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

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

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

- gloves
- wipes
- creams
- laundry (bedding)

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

(Please read. IT IS MANDATORY to have each box initialled.)	**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.	_____ _____

****MUST BE COMPLETED BY YOUR DOCTOR OR NURSE PRACTITIONER WITHIN 6 MONTHS OF APPLYING****
If information is incomplete, the form will be returned to the parent/legal guardian.

Primary Diagnosis (reason for incontinence) _____

Secondary to Chronic Disability/Condition _____

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: month _____ / day _____ / year _____ Signature: _____

SECTION 5 – PAYEE INFORMATION

(Must be completed and signed by person(s) who will be receiving the grant):

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 or split payments between parents.

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).

Payment Information **(Print in ALL CAPS) We are unable to accept electronically generated signatures.**

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: _____
Please provide and keep current a valid email address. Starting in 2024 program correspondence will be sent by email.

Original signature #1: _____ Date: month _____ / day _____ /year _____

Original signature #2: _____ Date: month _____ / day _____ /year _____

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

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. If any information is missing, the application will be returned to you for completion resulting in delay in processing the application.

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.

Please note: the continuation of the grant is conditional upon 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 His Majesty the King the Right of the Province of Ontario to Easter Seals Ontario.

(Please read. IT IS MANDATORY to have the box initialled.)	**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.	_____ _____

We are unable to accept electronically generated signatures.

Parent/Legal Guardian – print name: _____ Relationship to child: _____

Original signature: _____ Date: month _____ / day _____ /year _____

Parent/Legal Guardian – print name: _____ Relationship to child: _____

Original signature: _____ Date: month _____ / day _____ /year _____

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Incontinence Supplies Grant Program
Direct Deposit OPTION

SECTION 7

Should you wish to receive this grant as a direct deposit, please complete and sign the banking information below even if you include a blank cheque or info sheet from your bank.

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" or a direct deposit form from your bank.

ATTACH A VOID CHEQUE HERE

If unable to attach a void cheque or direct deposit form, please complete and sign the following information:

Transit # (5 digits): _____ Bank Branch # (3 digits): _____ Account #: _____

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

(Please note: incorrect information could result in your cheque being deposited into a wrong account)

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: month _____ / day _____ / year _____

Complete and send by:

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

Questions: 416.510.5074