Easter Seals Ontario — 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 in pen. FAXES or PHOTOCOPIES of this form will not be accepted. It is an offense to knowingly provide incorrect information on this application. Please Note: Program funding is a contribution towards the cost of supplies and may not cover all costs.

SECTION 1

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

Date of Birth (yyyy/mm/dd): _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone #: (_____)_____ Alternate # (work/cell): (_____)_____

Email: _____

Health Card #: _____ Version Code: _____

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: ☐ yes ☐ no Language: _____

Payment Information – Payment to be made to: *Name of Parent(s)/Legal Guardian(s)* acting as Payee(s)* If both parents are named as payees both must sign the application. Due to client confidentiality, information will only be released to the payee(s) listed on the application.

Name of Payee #1: _____ Relationship to child: _____

Name of Payee #2: _____ Relationship to child: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Signature of Payee #1: _____ Date (yyyy/mm/dd): _____

Signature of Payee #2: _____ Date (yyyy/mm/dd): _____

***Legal Guardians:** 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 ☐ no.

- 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
- I/We understand the information on this form is subject to review by Easter Seals Ontario.
- ***I/we have fully read the application guidelines and understand that it is my/our responsibility to keep all receipts for incontinence supplies purchased, as I/we will be required to participate in reviews while enrolled in the program.**

***Parent(s)/Legal Guardian(s) Please initial: _____/_____**

Parent/Legal Guardian #1 signature: _____ Date (yyyy/mm/dd): _____

Parent/Legal Guardian #2 signature: _____ Date (yyyy/mm/dd): _____

Please review the form before sending in to make sure all information is provided. **Please note: the grant begins after the application is approved; 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 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 Her Majesty the Queen the Right of the Province of Ontario to Easter Seals Ontario.

SECTION 2

Your Doctor or Nurse Practitioner must fill in this section. (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 child's diagnosis to his/her incontinence.

Chronic Disability: _____

Secondary Diagnosis: _____

Surgical Procedure & Date (if applicable): _____

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

Can the applicant 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

Can the applicant achieve bowel control? ☐ Yes ☐ No ☐ Unknown

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Check Level A OR Level B and indicate product type:
Applicants may be eligible to receive **either** Grant Level A or Grant Level B.

☐ **Grant Level A ($400/yr)**

↘ **Product Type:** ☐ Diapers (3-5 years) ☐ Intermittent/Foley catheters ☐ Reusable cloth diapers/liners

☐ **Grant Level B ($900/yr)**

↘ **Product Type:** ☐ Diapers (6-18 years) ☐ Male external catheters

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Persons may also be eligible for an additional grant if they use supplies required for ongoing bowel routines. Please indicate below whether or not the applicant requires these supplies.

☐ **Grant Level C ($200/yr)**

↘ **Bowel Management:** (3-18 years) (includes tubing and glycerin suppositories). It **DOES NOT INCLUDE** Fleet enemas or any medications (i.e. stool softeners, laxatives etc.)

☐ Used ☐ Not Used

Please indicate products, amount and frequency used: _____

I certify that the above named child/youth requires the personal use of incontinence supplies on an ongoing basis.

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

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

Address: _____ Telephone #: (_____)_____

Signature: _____ Date (yyyy/mm/dd): _____

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INCONTINENCE SUPPLIES GRANT PROGRAM

Direct Deposit OPTION

Section 3

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 #: (_____)_____ Alternate # (work/cell): (_____)_____

E-mail: _____

Child's name: _____

Child's Health Card No: _____ Version Code: _____

Please attach a blank cheque marked "void".

ATTACH A VOIDED CHEQUE HERE

If unable to attach a void check, 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 directly to the account indicated above.
This authorization will be in force until notice in writing is given to stop the direct deposit.

Signature: _____ Date Authorized (yyyy/mm/dd): _____

Return form to the Program Coordinator at:

Easter Seals Ontario, I.G. Program
One Concord Gate, Suite 700
Toronto, Ont. M3C 3N6

For inquiries, please contact:

(416) 421-8377 x 314
Toll Free 1-800-668-6252 x 314
www.easterseals.org