Helping Kids with Physical Disabilities Succeed

LEVEL B INCREASE FORM

IMPORTANT NOTES:

- **Grant Level B** is available when children are not physically or developmentally ready to train and costs are increasing (spending equivalent to or more than $900/year). If you need to apply for the increase, please **complete and return this form with 4 months of current receipts.** If you do not need the increase your payment can continue at Level A. Please keep this form to apply in the future if your spending increases.

STEP 1: Client Information (Please print in ALL CAPS):

IG Client ID # (*if unknown, please leave blank*)**:** _____

Childs Health Card #: _____ **Version Code**: _____ **Expiry Date**: _____

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

Date of Birth (mm/dd/yyyy): _____ Gender: Male: ____ Female: ____ X: ____

Please complete to ensure that the program has the most up to date information on file:

Address: _____

City: _____ Province: _____ Postal Code: _____

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

E-mail: _____

- Please ensure we have a current email address for program correspondence.
- If you need to make changes to your banking information, please fill out a new bank deposit form found at www.services.easterseals.org and submit to the program

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:

Level A / Level B: Diapers or Catheters (diapers, pull-ups, swimmers etc.)

Product(s) used: _____ Number used during day: _____/ night: _____ Cost per month: $_____

Catheters used: _____ Number used during day: _____/ night: _____ Cost per month: $_____

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STEP 3: Complete the chart by entering in the total amount you spent each month on incontinence products for the last 4 months. If you don't have your current receipts save for the next 4 months.

***Month**: Write the name of the month in first column
***Monthly Total:** Add all your receipts for each month and enter the total in the line for that month.

Note:
*Parents with more than one child registered do not need to separate receipts. **Please include the receipts for all children. Applications are assessed on the total expenses.**

*If for any reason you do not have the last 4 months receipts, save the next 4 months and submit at that time.

***We are not able to accept receipts that are dated over 6 months, unless your receipts are from a previous bulk purchase.**

Month	Total	Office use Verified
e.g. May	$ 42	
	$	☐
	$	☐
	$	☐
	$	☐

- **NOT COVERED** under the grant: Gloves, wipes, creams, prescriptions (including enemas), clothing/linens, laundry detergent and pads for menstrual period.

STEP 4: Return this form with the 4 months of receipts as you have written above.

- Receipts must be clear and show the complete receipt including: date of purchase/delivery, item purchased and amount spent.
- If submitting electronically by email or fax **please note: altered/folded receipts are not accepted. Online receipts must show shipping confirmation (we cannot accept an order form).**
  Fax: 416-696-1035 or **Email:** igprogram@easterseals.org
- **Receipts can also be mailed** (original receipts can be returned upon request; if not requested they are destroyed).
  Mail: Easter Seals Ontario, I.G. Program, 700-1 Concorde Gate, Toronto, ON, M3C 3N6
- You will receive a confirmation letter in the mail.

If your child becomes toilet trained please notify the program and return the payment you have just received, as it was to cover the next 6 months of incontinence supplies.

If you have any questions, please contact the program at 416-421-8778 x314 or by email at igprogram@easterseals.org.

❑ I have included **4 months of current receipts** with this form. Forms without **4 months** of receipts will not be processed. Misuse of funds is reportable to the Ministry of Health.

Parent/Legal Guardian:

Name (print): _____ **Signature:** _____ **Date**_____
(MM/DD/YYYY)

Name (print): _____ **Signature:** _____ **Date:** _____
(MM/DD/YYYY)