Easter Seals Ontario — Helping Kids with Physical Disabilities Succeed

Incontinence Supplies Grant Program Application

IMPORTANT NOTES:

- This application is for new Level A or Level B applicants or Re-Applications (see Application Type below).
- Level B Increase: If your child is currently receiving the Level A grant and you would like to apply for Level B, please submit 4 months of current, consecutive receipts with a Level B increase form. Do not complete this application.
- Visit igprogram.easterseals.org for more information about the program, guidelines and for a Level B Increase Form.
- All applications are processed in date received order. Please read and complete ALL sections of the application before submitting as incomplete applications will delay processing times.

Completed applications can be sent by mail, fax or email. Please keep a copy for your records.

- **Mail:** Easter Seals Ontario, Attention I.G. Program
  700 - 1 Concorde Gate
  Toronto, ON M3C 3N6
- **Fax:** 416-696-1035
- **E-mail:** igprogram@easterseals.org

PLEASE SELECT APPLICATION TYPE:

☐ **New Application: Level A** (3 - 5 years; $400/year) **OR** **Level B** (6 - under 18 years; $900/year)

☐ **Re-Application**: If your child was previously on the program but no longer receives the grant, please complete this application and include 4 months of current receipts. Re-applications do not require a signature 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 and initial EACH BOX.	**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 enclosed** (child is a Crown Ward, in a group home or there has been a change in parental custody).	_____ _____
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: ALL areas must be completed.

Funding levels for applications that meet the eligibility criteria are:
Level A (3 - 5 years; $400/year).
Level B (6 – under 18 years; $900/year).

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). You MUST provide estimated costs.

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 and initial EACH BOX.	**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.

***If this section does <u>not</u> apply, please proceed to Payee Information, Section 5.**

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 and initial EACH BOX.	**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.	_____ _____

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

Missing information will result in the application being returned and/or a delay in processing time.

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 the person/s who will be receiving the grant payments:

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 you submit. Missing information or incomplete applications may be returned to you and will delay processing times.

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 and initial EACH BOX.	**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 _____

Easter Seals™ Ontario
Helping Kids with Physical Disabilities Succeed

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
700 - 1 Concorde Gate
Toronto, ON M3C 3N6

Fax: 416-696-1035, *Attention I.G. Program*

E-mail: igprogram@easterseals.org

Questions: 416.421.8778 ext. 314