EASTER SEALS ONTARIO: REGISTRATION APPLICATION

Easter Seals Ontario™ Helping Kids with Physical Disabilities Succeed

FOR OFFICE USE ONLY:

Reviewed by: _____ Diagnosis Group: _____

Meets ES Eligibility Criteria: ☐ Yes ☐ No - _____ Diagnosis Primary: _____

Entered by: _____ Date Entered: _____ ESCR #: _____

IMPORTANT – PLEASE READ:

Please print clearly and complete all sections of the registration form in ink.

Section Four must be completed by the child's Occupational Therapist (OT) or Physiotherapist (PT) or Physician. In order to be eligible for registration the child must be a legal resident of Ontario who is under the age of 19 years, and must have a permanent **physical disability** that restricts their independent mobility and results in the use of, an ADP funded, primary mobility device such as a wheelchair or walker. Eligibility does **not** extend to children with a primary diagnosis of a developmental disability such as Autism, or a correctable condition.

If you are receiving funding from the Incontinence Supplies Grant Program you are not automatically a client of Easter Seals Ontario. The Incontinence Supplies Grant Program is administered on behalf of the Ministry of Health and Long-Term Care and is a completely independent program and a separate registry.

If your child meets Easter Seals Ontario's eligibility criteria, an information package will be sent to you. If your child does not meet the criteria, you will be notified with a letter. **Please allow 4 weeks to process your application. Once your child is registered with Easter Seals Ontario they will be a client until their 19th birthday, at which time they are discharged.**

SECTION ONE: DEMOGRAPHIC INFORMATION

(TO BE COMPLETED BY PARENT/GUARDIAN)

CHILD'S INFORMATION:

Last Name: _____ First Name: _____

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

Address: _____

City: _____ Postal Code: _____ Home #: (_____) _____

Do you prefer to be contacted by email? ☐ No ☐ Yes – if yes, email: _____

PARENT / LEGAL GUARDIAN(S) INFORMATION:

Guardian #1 – Relationship to child: _____

Last Name: _____ First Name: _____

Employer: _____ Cell #: (_____) _____

Guardian #2 – Relationship to child: _____

Last Name: _____ First Name: _____

Employer: _____ Cell #: (_____) _____

PARENT / LEGAL GUARDIAN(S) ADDRESS – ONLY IF DIFFERENT FROM ABOVE:

Address: _____

City: _____ Postal Code: _____

SECTION ONE (CONT'D): DEMOGRAPHIC INFORMATION *(TO BE COMPLETED BY PARENT/GUARDIAN)*

FOR STATISTICAL PURPOSES ONLY, PLEASE INDICATE YOUR TOTAL HOUSEHOLD INCOME:
☐ $0-$20,000 ☐ $20,001-$40,000 ☐ $40,001-$60,000 ☐ $60,001-$80,000 ☐ $80,001-$100,000 ☐ over $100,000
OTHER INFORMATION:
Main language spoken at home: _____ **Interpreter needed?** ☐ No ☐ Yes
How did you find out about Easter Seals? _____
Does your child live in a: ☐ Family Home ☐ Group Home ☐ Other: _____
Is the child's home wheelchair accessible? ☐ No ☐ Yes
Is the child a Crown Ward of Children's Aid Society? ☐ No ☐ Yes
IF THE CHILD IS A CROWN WARD THEN THEY ARE NOT ELIGIBLE FOR FUNDING FOR FINANCIAL ASSISTANCE FOR EQUIPMENT. THEY WILL RECEIVE RESOURCE INFORMATION AND ARE WELCOME TO ATTEND AN EASTER SEALS CAMP IF THEY MEET THE CAMP ELIGIBILITY CRITERIA AND PAY FULL FEES.

SECTION TWO: SUPPORT AND ASSISTANCE *(TO BE COMPLETED BY PARENT/GUARDIAN)*

Please answer all questions in this section as they will enable Easter Seals Ontario to direct you to the appropriate source of support.

DO YOU RECEIVE/ HAVE ANY OF THESE SERVICES?	
Special Services at Home (SSAH) Funding ☐ No ☐ Yes	Social Assistance (e.g. Ontario Works) ☐ No ☐ Yes
Assistance for Children with Severe Disabilities (ACSD) ☐ No ☐ Yes	Employer Extended Health Care Benefits ☐ No ☐ Yes
OTHER SOURCES OF ASSISTANCE YOU RECEIVE (e.g. OFCP, MUSCULAR DYSTROPHY CANADA, ETC):	
_____	
_____	
WHAT TREATMENT CENTRE AND/OR HOSPITAL(S) DOES YOUR CHILD GO TO - PLEASE LIST:	
_____	
_____	
DOES YOUR CHILD GO TO SCHOOL? ☐ NO ☐ YES – IF YES, PLEASE PROVIDE THE NAME OF THE SCHOOL AND SCHOOL BOARD:	
_____	
_____	

SECTION THREE: SERVICES REQUESTED *(TO BE COMPLETED BY PARENT/GUARDIAN)*

INDICATE WHICH SERVICES YOU WOULD BE INTERESTED IN RECEIVING / PARTICIPATING IN FROM EASTER SEALS ONTARIO:		
☐ Financial Assistance	☐ Camping	☐ Special Education Information
☐ Easter Seals Ontario e-newsletter – email: _____		
☐ Information on local Events/Activities (Regatta, Christmas Party etc) – please contact me via: ☐ e-mail ☐ phone		
I UNDERSTAND THAT THE INFORMATION PROVIDED WILL ONLY BE USED BY EASTER SEALS ONTARIO TO ASCERTAIN ELIGIBILITY FOR REGISTRATION AND TO SUPPORT THE NEEDS OF MY CHILD. I CERTIFY THAT ALL THE INFORMATION PROVIDED ON THE APPLICATION FORM IS TRUE.		
_____ Parent/Legal Guardian(s) Signature		_____ Date

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Helping Kids with Physical Disabilities Succeed

SECTION FOUR: CHILD'S DISABILITY

*(MUST BE COMPLETED BY **OT** OR **PT** OR **PHYSICIAN**)*

<u>This section must be completed by the client's Occupational Therapist OR a Physiotherapist or Physician, licensed to practise in Ontario.</u> Easter Seals is a charity that provides assistance to children and youth that have a *permanent physical disability*. Eligibility criteria requires that the child or youth will need to use an ADP funded mobility device on a permanent basis.

The child would <u>not be eligible</u> if his/her diagnosis is Developmental Disability and the Wheelchair or Stroller prescribed through the Assistive Devices Program was for safety.

If the child is under the age of 4 and it is not yet known if they will require mobility equipment, please wait until an assessment has been completed prescribing the child a permanent ADP funded mobility device.

DIAGNOSIS (PLEASE BE SPECIFIC):
_____
_____
DESCRIPTION OF DISABILITY – *describe how it affects daily living/mobility. Feel free to include a current OT/PT assessment that has been completed within the last 3 months.*
_____
_____
_____
_____

OVERVIEW OF GROSS MOTOR FUNCTIONS – CAN THE CHILD:			
Roll?	☐ No ☐ Yes ☐ With assistance	**Sit?**	☐ No ☐ Yes ☐ With assistance
Stand?	☐ No ☐ Yes ☐ With assistance	**Walk?**	☐ No ☐ Yes ☐ With assistance
Climb stairs?	☐ No ☐ Yes ☐ With assistance	**ADL's?**	☐ No ☐ Yes ☐ With assistance

IF APPLICABLE PLEASE SELECT THE GROSS MOTOR FUNCTION LEVEL?				
☐ Level I	☐ Level II	☐ Level III	☐ Level IV	☐ Level V

IF THE CHILD IS <u>BELOW THE AGE 4</u>, PLEASE COMPLETE THIS SECTION:				
Does the child walk in his/her immediate environment?				☐ No ☐ Yes ☐ With assistance
Does the child have orthotics?	☐ No ☐ Yes			
If yes, are they ADP funded?	☐ No ☐ Yes	Will they be required long term?		☐ No ☐ Yes ☐ Unable to determine
Does the child have a stroller?	☐ No ☐ Yes			
If yes, is it ADP funded?	☐ No ☐ Yes	Will it be required long term?		☐ No ☐ Yes ☐ Unable to determine
Will the child need long term mobility equipment in the future?				☐ No ☐ Yes ☐ Unable to determine
IF YOU ARE UNABLE TO DETERMINE IF THE CHILD IS GOING TO NEED MOBILITY EQUIPMENT ON A LONG TERM BASIS THEN THE REGISTRATION REQUEST SHOULD <u>NOT</u> BE COMPLETED AT THIS TIME.				

SECTION FOUR (CONT'D): CHILD'S DISABILITY

*(MUST BE COMPLETED BY **OT** OR **PT** OR **PHYSICIAN**)*

FOR ALL AGES - DOES THE CHILD HAVE:			
G-tube / J-tube:	☐ No ☐ Yes – type: _____	Seizures:	☐ No ☐ Yes – type: _____
Tracheostomy:	☐ No ☐ Yes	Shunt:	☐ No ☐ Yes – type: _____
Ventilator:	☐ No ☐ Yes	Impaired Hearing:	☐ No ☐ Yes
Verbal Skills:	☐ No ☐ Yes ☐ Limited	Impaired Vision:	☐ No ☐ Yes

DOES THE CHILD USE THE FOLLOWING EQUIPMENT?					
Manual Wheelchair	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Power Wheelchair	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Stroller	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Walker	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Stander	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Braces (AFO/KAFO)	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes
Oxygen		☐ No	☐Yes		
Bath/Shower Aids	☐ Being assessed	☐ No	☐ Yes		
Communication Device	☐ Being assessed	☐ No	☐ Yes – if yes, is it ADP funded?	☐ No	☐ Yes

DOES THE CHILD HAVE THE FOLLOWING? *CHECK (✓) ALL THAT APPLY*					
☐ Porch Lift	☐ Van Lift	☐ Track Lift	☐ Stair Lift	☐ Portable Lift	☐ Ramp

THERAPIST OR PHYSICIAN INFORMATION:	
Name: _____	☐ OT ☐ PT ☐ DR – Registration #: _____
Organization (e.g. CCAC, Treatment Centre, etc):_____	
Phone #: (_____) _____	E-mail: _____
Date (yyyy/mm/dd): _____ /_____ / _____	Signature: _____

COMPLETED APPLICATIONS CAN BE SENT VIA:

Mail: Registration, Easter Seals Ontario, 700-1 Concorde Gate, Toronto, Ontario, M3C 3N6

Fax: 416.696.1035 *(please send to the attention of Registration Provincial Services)*

E-mail: services@easterseals.org

Please note that it is the parent/guardian(s) responsibility to follow up with Easter Seals Ontario to ensure the application has been received. If you have any questions about the application, please do not hesitate to contact Provincial Services at 416.421.8146, toll free at 1.866.630.3336 or email services@easterseals.org.