EASTER SEALS ONTARIO: REGISTRATION APPLICATION

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). In order to be eligible for registration the child must be a legal resident of Ontario, have a valid Ontario Health Card, be under the age of 19 years, and must have a permanent **physical disability** that restricts their independent mobility and results in the use of a primary mobility device such as long-term orthotics, wheelchair or walker.

*Eligibility does **not** extend to children that are not using a primary mobility device.*

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, with a separate application form and eligibility criteria.

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. All equipment funding requests must be submitted 6 months prior to their 19th birthday.**

SECTION ONE: DEMOGRAPHIC INFORMATION

(TO BE COMPLETED BY PARENT/GUARDIAN)

CHILD'S INFORMATION:

First Name: _____ **Last Name**: _____

Date of Birth (mm/dd/year): _____ / _____ / _____ Gender: _____

OTHER INFORMATION:

Main language spoken at home: _____ Interpreter needed? ☐ Yes ☐ No

If YES, please list a contact person you would like to have on file to act as an interpreter:

Name: _____ Phone Number: (_____) _____Relationship to Child: _____

How did you find out about Easter Seals? _____

Does your child live in a: ☐ Family Home ☐ Group Home ☐ Other: _____

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 TO APPLY FOR THE EQUIPMENT FUNDING PROGRAM.
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.

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PARENT / LEGAL GUARDIAN(S) INFORMATION

GUARDIAN #1 (PRIMARY CONTACT) This contact will be the main contact on file to whom all correspondence will be sent.

Name: _____ Relationship to Child: _____
First Name Last Name (example, mother, father, grandparent etc)

Address: _____ City: _____ Postal Code: _____

Primary Phone: (_____)_____ Secondary Phone: (_____)_____

Email:_____

Please Note: Email is our primary method of communication for Easter Seals Services (equipment funding and recreation). If no email is provided, you will receive all correspondence by mail.

Does your child live at the same address? ☐ Yes ☐ No

GUARDIAN #2 (SEONDARY CONTACT) This contact will be listed on file and information can be shared with this contact.

Name: _____ Relationship to Child: _____
First Name Last Name (example, mother, father, grandparent etc)

Same address as primary contact? : ☐ Yes ☐ No Cell #: (_____) _____

CHILD ADDRESS – ONLY IF DIFFERENT FROM PRIMARY CONTACT ADDRESS

Address: _____

City: _____ Postal Code: _____

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.

DOES YOUR CHILD RECEIVE/ HAVE ANY OF THESE SERVICES?			
A valid Ontario Health Card?	☐ Yes ☐ No	Receiving Interim Federal Health?	☐ Yes ☐ No
Employer Extended Health Care Benefits	☐ Yes ☐ No		
WHAT TREATMENT CENTRE AND/OR HOSPITAL(S) DOES YOUR CHILD GO TO - PLEASE LIST:			

SECTION THREE: AUTHORIZATION

(TO BE COMPLETED BY PARENT/GUARDIAN)

I UNDERSTAND EASTER SEALS ONTARIO MAY CARRY OUT INQUIRIES FOR THE PURPOSE OF CONFIRMING OR CLARIFYING THE INFORMATION SUBMITTED, PROCESSING THE APPLICATION, ADDRESSING AN APPEAL, OR WITH ANY OTHER AGENCY LISTED ON THIS APPLICATION FORM. I FURTHUR UNDERSTAND AND AGREE THAT THESE INQUIRES MAY REQUIRE EXCHANGE OF INFORMATION THAT MAY TAKE THE FORM OF ELECTRONIC DATA EXCHANGE.

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

☐ **Yes! I consent to be contacted by Easter Seals Ontario Staff to be notified of opportunities to participate in marketing or promotional initiatives for the organization. This may include sharing your experience with Easter Seals Ontario programs and services, as well as discussing the positive impact they have had on your family.**

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SECTION FOUR: CHILD'S DISABILITY

MUST BE COMPLETED BY Occupational Therapist or Physiotherapist, licensed to practice in Ontario.

Please complete all questions. If the Registration is not complete it will be returned and will not be processed.

Easter Seals Ontario is a charity that provides assistance to children and youth that have a permanent physical disability that results in the need to use a mobility device as a primary device.

Easter Seals Ontario reserves the right to determine if an applicant meets the eligibility criteria.

Eligibility criteria requires that the child or youth will need to use a long-term mobility device as a primary device, such as LONG-TERM orthotics, walker or wheelchair. Long-term = required for life.

The child would not be eligible if:

- **The ADP funded stroller/wheelchair is being used only for long distance, fatigue or lack of endurance**
- **The stroller or wheelchair has been prescribed and approved by the Assistive Devices Program for *safety only*.**

If it is not yet known if the child will require mobility equipment, please wait to register until an assessment has been completed prescribing the child a long-term mobility device.

DIAGNOSIS (PLEASE BE SPECIFIC):

_____

_____

DESCRIPTION OF DISABILITY – *describe how it affects daily living/mobility. Focus on impact on the child's 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

Walk with Assistance:
How far independently? _____

Type of assistance: Hand Holding? ☐ No ☐ Yes Holding on to objects? ☐ No ☐ Yes Equipment? ☐ No ☐ Yes

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

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IF THE CHILD IS UNDER THE AGE 6, PLEASE COMPLETE THIS SECTION:			
Does the child walk in his/her immediate environment at home? If YES with assistance, please give a detailed description: _____	☐ No ☐ Yes ☐ With assistance		
Does the child walk in his/her immediate environment at school? If YES with assistance, please give a detailed description: _____	☐ No ☐ Yes ☐ With assistance		
Does the child have orthotics?	☐ No ☐ Yes	What type of orthotics? _____	
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 yes, will the mobility equipment be prescribed: ☐ within 6 months ☐ 1 to 2 years ☐ 5 years ☐ Longer

******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 NOT BE COMPLETED AT THIS TIME.******

FOR ALL AGES - IS THE CHILD:

Incontinent: ☐ **No** ☐ **Yes ***

***If yes**, please visit www.services.easterseals.org the Incontinence Supplies Grant Program to download the guidelines and application form. **The Incontinence Supplies Grant Program is administered on behalf of the Ministry of Health and is a completely independent program with separate eligibility criteria and application form.**

DOES THE CHILD USE THE FOLLOWING EQUIPMENT?	
Mobility equipment that was prescribed outside of Ontario?	☐ No ☐ Yes If yes: From where?
Stroller	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes Being used for all mobility outside of the home? ☐ No ☐ Yes Being used for long distance only? ☐ No ☐ Yes Being used for safety so child is not able to run away? ☐ No ☐ Yes Being used for transportation to school? ☐ No ☐ Yes Being used within the school? ☐ No ☐ Yes Is this the child's first ADP funded stroller? ☐ No ☐ Yes
Manual Wheelchair	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes Can child propel own chair? ☐ No ☐ Yes Is this the child's first ADP funded wheelchair? ☐ No ☐ Yes

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SECTION FOUR (CONT'D): CHILD'S DISABILITY (MUST BE COMPLETED BY OT OR PT)

Power Wheelchair	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes Is this the child's first ADP funded power wheelchair? ☐ No ☐ Yes
Walker	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes
Stander	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes
Braces (AFO's/KAFO's)	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes
Bath/Shower Aids	☐ No ☐ Yes ☐ Being assessed
Communication Device	☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes ☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes

DOES THE CHILD HAVE THE FOLLOWING? *CHECK (✓) ALL THAT APPLY*

☐ Porch Lift ☐ Van Lift ☐ Track Lift ☐ Stair Lift ☐ Portable Lift ☐ Ramp

THERAPIST INFORMATION:

Name: _____ ☐ OT ☐ PT – Registration #: _____

Organization (e.g. CCAC, Treatment Centre, etc): _____

Phone #: (_____) _____ E-mail: _____

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

COMPLETED APPLICATIONS CAN BE SENT VIA:

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

Fax: 416-696-1035 (Attn: 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 at services@easterseals.org.

If required, and upon request, Easter Seals Ontario will provide or arrange for the provision of this form in an accessible format and/or provide communication supports related to this form for persons with disabilities.