# EASTER SEALS ONTARIO: REGISTRATION APPLICATION

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).** In order to be eligible for registration the child must be a legal resident of Ontario, have a valid Ontario Health Card, 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 #: (_____) _____

email: _____ Do you prefer to be contacted by email? ☐ No ☐ Yes

### 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: _____

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## SECTION ONE (CON'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 |
| ☐ $100,001-$120,000 | ☐ $120,001-$140,000 | ☐ $140,001-$160,000 | ☐ $160,001-$180,000 | ☐ $180,001-over |

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.*

| DOES YOUR CHILD RECEIVE/ HAVE ANY OF THESE SERVICES? | | | |
|---|---|---|---|
| A valid Ontario Health Card? ☐ No ☐ Yes | | Receiving Interim Federal Health? ☐ No ☐ Yes | |
| 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:**

_____

## 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 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 |

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

**This section must be completed by the client's Occupational Therapist OR a Physiotherapist, licensed to practise 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 an ADP funded long-term mobility device as a primary device, such as a walker or wheelchair.**

**The child would not be eligible if his/her ADP funded stroller/wheelchair is being used only for long distance, fatigue or lack of endurance.**

**The child would not be eligible if his/her diagnosis is Developmental Disability and the stroller or wheelchair has been prescribed through the Assistive Devices Program for safety.**

**If the child is under the age of 6 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. 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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## SECTION FOUR (CONT'D): CHILD'S DISABILITY (MUST BE COMPLETED BY OT OR PT)

**IF THE CHILD IS BELOW THE AGE 6, PLEASE COMPLETE THIS SECTION:**

Does the child walk in his/her immediate environment at home? ☐ No ☐ Yes ☐ With assistance
If with assistance please give a detailed description:
_____

Does the child walk in his/her immediate environment at school? ☐ No ☐ Yes ☐ With assistance
If with assistance please give a detailed description:
_____

**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: ☐ 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 - 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 |

Incontinent: ☐ No ☐ Yes *****

***If yes**, please visit www.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 Long-Term Care and is a completely independent program and a separate registry.**

**DOES THE CHILD USE THE FOLLOWING EQUIPMENT?**

| | |
|---|---|
| Stroller | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes<br>Being used for all mobility outside of the home? ☐ No ☐ Yes<br>Being used for long distance only? ☐ No ☐ Yes<br>Being used for safety so child is not able to run away? ☐ No ☐ Yes<br>Being used for transportation to school? ☐ No ☐ Yes<br>Being used within the school? ☐ No ☐ Yes<br>Is this the child's first ADP funded stroller? ☐ No ☐ Yes |
| Manual Wheelchair | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes<br>Can child propel own chair? ☐ No ☐ Yes<br>Is this the child's first ADP funded wheelchair? ☐ No ☐ Yes |
| Power Wheelchair | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes<br>Is this the child's first ADP funded power wheelchair? ☐ No ☐ Yes |

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

| | |
|---|---|
| Mobility equipment that was prescribed outside of Ontario? | ☐ No ☐ Yes<br>If yes: From where? |
| Walker | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes |
| Stander | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes |
| Braces (AFO/KAFO) | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ Being assessed- if selected, will it meet ADP criteria? ☐ No ☐ Yes |
| Oxygen | ☐ No ☐Yes |
| Bath/Shower Aids | ☐ No ☐ Yes ☐ Being assessed |
| Communication Device | ☐ No ☐ Yes – if yes, is it ADP funded? ☐ No ☐ Yes<br>☐ 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 (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.**

**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.**