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| This fund supports Holland Bloorview clients who need financial help to support their health and well-being during exceptional circumstances. Completed applications will be considered for a decision. Complete the application package in full, along with any other required documents. If your application has missing information, it will likely affect the timing and outcome of your request.  **General inquiries:**  Dennisse Carrasco  [dcarrasco@hollandbloorview.ca](mailto:dcarrasco@hollandbloorview.ca)  (416) 425-6220 ext. 6303    For eligibility criteria and application instructions, please see the infographic document (available online [HERE](https://hollandbloorview.ca/sites/default/files/2020-04/FSF-Fund%20Infographic-COVID19%20Response.pdf))  For eligibility criteria and application instructions, please see the infographic document (available online [HERE](https://hollandbloorview.ca/sites/default/files/2020-04/FSF-Fund%20Infographic-COVID19%20Response.pdf)) | |
| For eligibility criteria and application instructions, please see the infographic document (available online [HERE](https://hollandbloorview.ca/sites/default/files/2020-04/FSF-Fund%20Infographic-COVID19%20Response.pdf)) complete applications include: Signed & Dated application form A letter of support for each item/service requested A quote or an invoice for each item/service requested. Any other requested documents as required |
|
| **Administration use only:**  Application ID #: |

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| Client last name | | | | Client first name | Middle initial | | Date of birth (DD/MM/YYYY) |
| Parent/guardian last name | | | | Parent/guardian first name | Relation to client | | |
| Parent/guardian last name | | | | Parent/guardian first name | Relation to client | | |
| Apartment # | Address | | | | | | |
| City | | Province | | | Postal code | | |
| Home phone | | Cell phone | | | Work phone | | |
| Email address (might be used to inform you of decision) | | | | | | | |
| **Is an interpreter required?** Y  N | | | **CLIENT AND FAMILY INFORMATION** If yes, what language? | | | | |
| **Did a Holland Bloorview staff member help you fill out this application?** YES / NO | | | | | | | |
| Please complete this section if you agree to share your child’s **name, date of birth** and **amount of funding received** with the HB staff person who helped fill out this form. This means that they can know you got this funding. | | | Staff’s Name: | | | Title: | |
| Phone with Ext: | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Parent / Guardian signature** Agree to notify the specified HB staff. | |

**SEE PAGE 2 FOR CONSENT SIGNATURES**

**Agreement with Holland Bloorview Kids Rehabilitation Hospital**

The personal information you give us on this form allows us to administer the Family Support Fund. We collect, use and share this information under the authority of the Public Hospitals Act. If you have questions, please contact the privacy office at 416-425-6220 ext. 3467 or [privacy@hollandbloorview.ca](mailto:privacy@hollandbloorview.ca).When you request funding from the Holland Bloorview Family Support Fund, you must also agree to the following terms. Please make sure you understand these terms before you sign this application.

1. Holland Bloorview is not responsible for any harm that may come from your request for money.
2. Holland Bloorview is not taking part in your agreement with people or companies for equipment or services.

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| I have read, understood and agree the above terms with Holland Bloorview Kids Rehabilitation Hospital.  I confirm that the information provided in this application is true and complete to the best of my knowledge and understanding. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Parent / guardian’s signature Date (DD/MM/YYY)** |  |

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| **Clinical background information** | | | | | |
| **In the past 2 years, my child used these Holland Bloorview service(s):** | | | | | |
| Brain Injury Rehabilitation Team (BIRT)  Cleft Lip & Palate & Craniofacial (Cleft)  Communication & Writing Aids (Writing)  Complex Continuing Care (CCC)  Occupational Therapy (OT)  Feeding and Saliva Clinic (Feeding)  Lifespan | | Neuromotor clinic  Neuromuscular clinic  Pediatrician  Physiotherapy (PT)  Prosthetics and/or Orthotics  Psychology (Psych)  Psychopharmacology Clinic  Seating Clinic | | | Specialized Orthopedic Development Rehabilitation (SODR)  Speech language pathology (SLP)  Spina Bifida & Spinal Cord  Social Work  Transitions, Recreation & Life Skills (TR)  Other: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\*some revenue generating programs*  *do not qualify (see eligibility criteria* [*HERE*](https://hollandbloorview.ca/our-services/family-workshops-resources/holland-bloorview-family-support-fund)*)* |
| Y  N | **My child is currently admitted as an inpatient at Holland Bloorview** | | Y  N | **My child currently participates in any recreation programs**  If yes, please specify: | |
| Y  N | **I have applied to the Family Support Fund between April 1, 2021 and March 31, 2022**  If yes, I was approved for $\_\_\_\_\_\_\_\_\_ | | | | |
| Y  N | **I am applying for a Holland Bloorview program or an item provided by a Holland Bloorview healthcare professional** | | | | |
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| **My family’s (household) yearly income is:** | | Under $26,000  **FINANCIAL BACKGROUND INFORMATION**  Between $26,000 and $45,000 | | | Between $45,000 and $95,000  Above $95,000 |
| **My family’s financial situation can be described as:** | | I am receiving social assistance (Ontario Disability Support Program, Ontario Works, or Assistance for Children with Severe Disabilities)  There are no other funding options available for this item / program | | | I have other funding options but this item / program is very expensive  I have a significant income but lots of expenses due to my child’s disability  I have applied for other funding options but have been denied. |

1. You agree to not ask Holland Bloorview to pay you back for any harms that arise from people or companies who sell you equipment or services.
2. Holland Bloorview does not make suggestions for people or companies who might help you or provide services to you / your family.

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| **My family circumstance(s):** Please check all that apply | There is a need for caregiver relief and support Caregiver job loss Single parent family There are other medical / health issues in the family We have more than one child with special needs (explain below) |
| **Family Household Occupants:**  These many adults live in my home: \_\_\_\_\_  These many children live in my home: \_\_\_\_ **Please tell us more about:****Your financial situation****The areas of stress in your life** **Your child’s needs****How this specific item/service will help your child and family** These factors are considered when applications are being reviewed. The more you can tell us, the better we can help. |  |

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| Y  N | I am willing to be contacted to give feedback regarding this funding application.(The funding application will not be impacted in any way by the response) |

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| **FUNDING CATEGORIES: ITEMS AND AMOUNT REQUESTED – THE LIMIT IS UP TO $1000\* FOR THE YEAR** **(If your overall ask exceeds the category cap, it will be reduced to meet application criteria)** | | |
| **Client Safety** \*These items try to reduce the client’s immediate safety concerns at home, at school, on transit, and to their overall health.  \*Items ***may*** be considered for **UP TO $1500** | | |
| Equipment(Maximum of $1500)Item/Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **You are asking for: $\_\_\_\_\_\_\_\_\_**  \*Equipment funding ***may*** be considered for **UP TO $1500** if costs surpass $1500 for an individual item or transaction | **What items qualify:**  \*Wheelchairs, walkers, standers, commodes, AFO’s, serial castings, limb prosthetics, mobility aids (e.g. lap belts, canes), catheterization equipment, suction machine, oxygen machine, other respiratory devices (e.g. BiPAP), helmets, feeding pumps, hearing aids, specialized vision aids, splints, hand braces, bathing systems, transfer boards.  Communication devices, writing aids, sensory equipment, foot orthotics (inserts), hospital mattresses, backup-wheelchairs, lifts, access ramps, special car seats, accessibility modifications for vehicle or home (integration of accessible equipment for home/vehicle will be considered, does not include cost of car or home building material or repairs) | **Documentation Needed:**  Support letter from:  Occupational therapist, Physiotherapist, Prescriber, Nurse Practitioner **OR** Physician  Quote or invoice from the chosen company  If you are eligible for insurance, please provide a letter indicating the outstanding balance  \*Safety related equipment may be prioritized, should additional documentation be required, Family Support Fund will reach out to applicant |
| Medication (Prescribed) (Maximum of **$500**) Item/Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_You are asking for: $ \_\_\_\_\_\_\_ | **What items qualify:**   * Registered prescribed medication (not over the counter) with an assigned Drug Insurance Number (DIN) that is *not* covered by OHIP, or medical insurance. * Medication not covered by OHIP Plus that is critical for your child’s health | **Documentation Needed:**  Support letter from: Nurse Practitioner **OR** Physician  Actual medication prescription  (from the Physician prescribing the medication)  Quote or invoice from the chosen pharmacy  If you are eligible for insurance, please provide a letter indicating the outstanding balance |
| **Wellness and quality of life** These items/services are to reduce possible risk of harm through caregiver support, lived experiences, social activity and recreation programs. Services & programs offer your child/client the chance to improve their quality of life, as well as offering caregiver relief. | | |
| Recreation (Maximum of **$500**) Item/Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_You are asking for: $ \_\_\_\_\_\_\_ | **What items qualify:**  Recreational programs that are not therapy led (therapy and/or treatment goals) i.e. social based programs, sports, summer camp, art programs and social activities will be considered. | **Documentation Needed:**  Support letter from:  Social Worker, Therapeutic Recreation Staff, Physiotherapist, Youth Worker staff **OR** Physician  Quote or invoice for the program |
| Respite/Childcare: at home or at camp(Maximum of $1000)Item/Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**You are asking for: $ \_\_\_\_\_\_\_** \*does not include recreational programs | **What items qualify:**   * Respite at a known respite facility (including Holland Bloorview) or agency (e.g. 1:1 care, not camp costs, no nursing) * Respite provided to the client through non-agency worker (e.g., family caregiver) * Respite provided to a client attending a camp program * Respite services provided to the client at home by a recognized organization offering respite care | **Documentation Needed:**  Support letter from:  Social Worker **OR** Physician  For **non-agency workers** or **childcare providers**: A “support worker invoice” form has to be filled and attached to the application  For agency workers: A quote or invoice from a recognized organization that offers respite care  See [HERE](https://hollandbloorview.ca/sites/default/files/2020-04/Respite%20Worker%20Claim%20Form%202020-2021.pdf) for support worker invoice claim form. |