Holland Bloorview
Kids Rehabilitation Hospital

FAMILY SUPPORT FUND APPLICATION 2020-2021

THIS POST-PAUSE FORM ACTIVATES JANUARY 1ST & EXPIRES AFTER MARCH 31ST, 2021

This fund supports Holland Bloorview clients who need financial help to support their health and well-being during exceptional circumstances.

NOTICE TO APPLICANT: Due to an increase in applications, only clients and families that have received **less than** $1500 from the Family Support Fund, between April 1st, 2020 and January 1st, 2021, will be permitted to access the Fund. If you have already received more than $1500 from the Fund between April 1st, 2020 and January 1st 2021 we ask that you re-apply effective April 1st, 2021.

*Please read page 4 carefully, as our category funding caps have changed

COMPLETED APPLICATIONS WILL BE CONSIDERED FOR A DECISION. IF YOU CHOSE TO SUBMIT AN INCOMPLETE APPLICATIONS WITH MISSING INFORMATION, IT WILL AFFECT THE TIMING & OUTCOME OF YOUR REQUEST.

For eligibility criteria and application instructions, please see the infographic document (available online HERE)

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 #:

CLIENT AND FAMILY INFORMATION

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 If yes, what language?

***Optional section* - HOLLAND BLOORVIEW STAFF ONLY**

Did a Holland Bloorview staff member help you fill out this application?

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.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.
3. 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.
4. Holland Bloorview does not make suggestions for people or companies who might help you or provide services to you / your family.

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)**

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
- ☐ Communication & Writing Aids
- ☐ Complex Continuing Care (CCC)
- ☐ Occupational Therapy
- ☐ Feeding and Saliva Clinic
- ☐ Lifespan
- ☐ Neuromotor clinic
- ☐ Neuromuscular clinic
- ☐ Pediatrician
- ☐ Physiotherapy
- ☐ Prosthetics and/or Orthotics
- ☐ Psychology
- ☐ Psychopharmacology Clinic
- ☐ Seating Clinic
- ☐ Specialized Orthopedic Development Rehabilitation (SODR)
- ☐ Speech language pathology
- ☐ Spina Bifida & Spinal Cord
- ☐ Social Work
- ☐Transitions, Recreation & Life Skills
- ☐ Other: *(please share)* - **some revenue generating programs do not qualify*

☐ 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, 2020 and March 31, 2021** 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**	

FINANCIAL BACKGROUND INFORMATION

My family's (household) yearly income is:	☐ Under $26,000 ☐ 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.

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.	
☐ 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)

FUNDING CATEGORIES: ITEMS AND AMOUNT REQUESTED – THE LIMIT IS UP TO $1500* 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: $**_____	**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, accessibility modifications/renovations for vehicle or home (including special car seats, does not include cost of car or home building material)	**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 *During the remainder of this fiscal year, safety related equipment may be prioritized
☐ **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

CLIENT WELLNESS

These items are to reduce possible risk of harm, and offer your child/client the chance to improve their quality of life through lived experiences, social activity and recreation programs. Review maximums carefully.

☐ **Emergent Needs** (Maximum of **$1000**) Item/Service: _____ **You are asking for: $** _____	**What items qualify:** This category was created in response to the financial distress brought on by COVID19's pandemic period and is not guaranteed to be funded in the future. You may use this category to apply for support with: **Food security, Shelter or Clothing and Hygienic product security**	**Documentation Needed:** ☐ Support letter from: Occupational therapist, Physiotherapist, Prescriber, Nurse Practitioner **OR** Physician ☐ Provide a copy of previous receipts indicating the cost: **Example:** rent/mortgage receipt, grocery shopping receipt, clothing store receipt.
☐ **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. Only social based programs, sports, summer camp, art programs and social activities will be considered.	**Documentation Needed:** ☐ Support letter from: Social Worker, Therapeutic Recreation Staff, Youth Worker staff **OR** Physician ☐ Quote or invoice for the program

CAREGIVER WELLNESS/HARM REDUCTION

These items offer caregiver support. We recognize caregivers can experience mental and physical fatigue due to caring for their child's daily needs. (Does not include recreational programs. For recreational programs see "Recreation" category)

☐ **Respite/Childcare: at home or at camp** (Maximum of **$1000**) Item/Service: _____ **You are asking for: $** _____	**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 for respite worker claim form.