Holland Bloorview
Kids Rehabilitation Hospital

FAMILY SUPPORT FUND APPLICATION 2019-2020

This fund was created to support Holland Bloorview clients who need financial help to support their health and well-being during exceptional circumstances. **The more you can tell us, the better we can help!**

TO BE CONSIDERED FOR FUNDING, YOUR CHILD MUST (SEE INSTRUCTIONS)

- ☐ Have had a clinical appointment with Holland Bloorview within two years of the date on this application
- ☐ Be under the age of 19
- ☐ Have all supporting documents must be attached to the application (Quote/letter of support)

Administration use only
Application ID#:

Administration use only
Client's hospital #:

CLIENT AND FAMILY INFORMATION (SECTION A)

Client's last name	Client's first name	Middle initial	Date of birth (DD/MM/YYYY)
Parent's (guardian's) last name	Parent's (guardian's) first name	Relationship to the child	
Parent's (guardian's) last name	Parent's (guardian's) first name	Relationship to the child	

Address — Apartment #

City — Province — Postal code

Home phone — Work phone — Cell phone

Email address (might be used to inform you of decision)

Is an interpreter required?
☐ Y ☐ N — If yes, what language?

FOR INTERNAL HOLLAND BLOORVIEW STAFF (SECTION B)

Staff's Name: — Title:

With your permission, we will share the results of this application with the person who helped you fill out this form so that they know you have this funding. If you agree to share your child's **name, date of birth** and **amount of funding received**

Phone with ext:

Parent / Guardian's signature

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 might 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 will 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 and understand the above terms with Holland Bloorview Kids Rehabilitation Hospital and I agree to it.

I confirm that the information provided in this application is true, correct and complete to the best of my understanding.

______________________ **Parent / guardian's signature**	DD/MM/YYYY Date

SECTION C: ☐ Y ☐ N	**Are you applying for a Holland Bloorview program or an item provided by a Holland Bloorview Healthcare professional?**	
Please check the clinical program area(s) that your child has used within the past 2 years		
☐ Cleft Lip & Palate & Craniofacial ☐ Occupational Therapy ☐ Communication & Writing Aids ☐ Pediatrician ☐ Feeding and Saliva Clinic ☐ Prosthetic and Orthotic	☐ Brain Injury Rehabilitation Team (BIRT) ☐ Complex Continuing Care (CCC) ☐ Specialized Orthopedic Development Rehabilitation (SODR) ☐ Psychology ☐ Psychopharmacology Clinic ☐ Physio Therapy ☐ Speech language pathology	☐ Seating Clinic ☐ Lifespan ☐ Social Work ☐ Neuromotor / Neuromuscular ☐ Spina Bifida & Spinal Cord ☐Transitions, Recreation & Life Skills
☐ Y ☐ N **My child is a current inpatient at Holland Bloorview**	☐ Y ☐ N **My child is currently participating in recreational programs** If yes, please specify:	
☐ Y ☐ N	**Have you applied to the Family Support Fund between April 1/19 to March 31/20?** If yes, how much did you receive? $________	
Please check your family's current yearly income	☐ Under $26,000 ☐ Between $26,000 and $45,000	☐ Between $45,000 and $95,000 ☐ Above $95,000
Please check the statements that best describe your financial situation	☐ I am receiving social assistance (Ontario Disabilities Support Program, Ontario Works, or Assistance to 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.

How many adults live in your house?	How many children live in your house?
Family Circumstances Please check all of the statements that apply	☐ There is a need for parental relief and support ☐ Parental job loss ☐ Single parent family ☐ We have other medical / health issues in the family ☐ We have more than one child with special needs (explain below)
Please tell us more about: **1. your financial situation,** **2. the areas of stress in your life,** **3. your child's needs,** **4. how this item/service will help your child and family.** These factors are considered when applications are being reviewed.	

☐ Y ☐ N	I am willing to be contacted to share my feedback regarding this funding application. (Your funding application will not be impacted in any way by your response)

SECTION D: PLEASE INDICATE THE ITEM/SERVICE AND THE AMOUNT OF FUNDING YOU ARE ASKING FOR NEXT TO YOUR SELECTED CATEGORY (provide 1 quote/cost estimate for each selected item/service)

CLIENT SAFETY

This category aims to reduce the client's immediate safety concerns at home, at school, on transit and to their health

Category	Requirements
☐ **Equipment** (Maximum of $1500) Indicate Item/Service: _____ **Indicate Amount: $** _______	• Support letter from Occupational therapist, Physiotherapist, prescriber **OR** Physician required • Qualifying Items: Wheelchairs, walkers, Standers, commodes, AFO's ,serial castings, prosthetics, mobility aids e.g. lap belts, canes, catheterization equipment, suction machine, oxygen machine, other respiratory devices (e.g. BiPAP), helmets, feeding pumps

☐ **Prescription medication**
(Maximum of $500)
Indicate Item/Service: _____
Indicate Amount : $ _______
	• Support letter from prescribing Physician required
	• Before submitting your application to the family support fund, please review the document "Drugs Funded by Ontario Drug Benefit (ODB) Program" to see if the drug you are looking to fund is covered by OHIP.
	• http://www.health.gov.on.ca/en/pro/programs/drugs/edition_42.aspx).
	• What is covered:
	  ○ Registered prescribed medication with an assigned Drug Insurance Number (DIN) that is not covered by OHIP, or medical insurance.
	  ○ Medication that is critical for your child's health but is not covered by OHIP Plus

CLIENT WELLNESS

This category aims to address potential risk of harm and to offer your child/client the chance to improve their quality of life through lived experiences, social activity and recreation programs

Category	Requirements
☐ **Equipment** (Maximum of $1000) Indicate Item/Service: _____ **Indicate Amount: $** _______	• Support letter from Occupational therapist, Physiotherapist, prescriber **OR** Physician required • Qualifying Items; Communication devices, sensory equipment, back up wheelchairs, writing aids, lifts, access ramps, hearing aids, specialized vision aids, splints, foot orthotics, accessible vehicle modification, accessible home modification and/or accessibility based home renovation, toileting support items, hospital mattresses
☐ **Recreation** (Maximum of $500) Indicate Item/Service: _____ **Indicate Amount : $** _______	• Support letter from Social Worker, Therapeutic Recreation staff **OR** Physician required • Recreational programs that are not therapy led (therapy and treatment goals) i.e. social based programs, sports, summer camp, art program

CAREGIVER WELLNESS/SAFETY

This category offers caregiver support. We recognize that caregivers can experience mental and physical fatigue due to caring for their child's daily needs and the family's needs

Category	Requirements
☐ **Respite: at home and at camps** (Maximum of $500) Indicate Item/Service: _____ **Indicate Amount : $** _______	• Support letter from Social Worker **OR** Physician required • This category includes respite services provided to the client at home (not by primary caregiver); at a known respite facility including Holland Bloorview Kids Rehabilitation Hospital or agency; and respite provided to a client attending a camp program. Respite services at home must be provided from a recognized organization that offers respite care (examples include: Respiteservices.com, VHA, etc.).
☐ **Transportation – Does not include taxi chits/reimbursement** (Maximum of $250) Indicate Item/Service: _____ **Indicate Amount : $** _______	• Support letter from Social Worker **OR** Physician required • Transportation costs will only be approved if the client resides within TTC (Toronto Transit Commission) limits and can provide proof that Wheeltrans denied them as a customer. • Clients who reside out of TTC catchment and drive to Holland Bloorview for appointments