

# 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 19<sup>th</sup> 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 <u>ONLY</u> , PLEASE INDICATE YOUR TOTAL HOUSEHOLD INCOME:				
<input type="checkbox"/> \$0-\$20,000	<input type="checkbox"/> \$20,001-\$40,000	<input type="checkbox"/> \$40,001-\$60,000	<input type="checkbox"/> \$60,001-\$80,000	<input type="checkbox"/> \$80,001-\$100,000
<input type="checkbox"/> \$100,001-\$120,000	<input type="checkbox"/> \$120,001-\$140,000	<input type="checkbox"/> \$140,001-\$160,000	<input type="checkbox"/> \$160,001-\$180,000	<input type="checkbox"/> \$180,001-over
OTHER INFORMATION:				
Main language spoken at home: _____ Interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes				
How did you find out about Easter Seals? _____				
Does your child live in a: <input type="checkbox"/> Family Home <input type="checkbox"/> Group Home <input type="checkbox"/> Other: _____				
Is the child's home wheelchair accessible? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is the child a Crown Ward of Children's Aid Society? <input type="checkbox"/> No <input type="checkbox"/> Yes				
IF THE CHILD IS A CROWN WARD THEN THEY ARE <u>NOT</u> 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.

<b>DOES YOUR CHILD RECEIVE/ HAVE ANY OF THESE SERVICES?</b>			
A valid Ontario Health Card?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Receiving Interim Federal Health?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Special Services at Home (SSAH) Funding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Social Assistance (e.g. Ontario Works)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Assistance for Children with Severe Disabilities (ACSD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Employer Extended Health Care Benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>OTHER SOURCES OF ASSISTANCE YOU RECEIVE (e.g. OFCP, MUSCULAR DYSTROPHY CANADA, ETC):</b>			
_____			
<b>WHAT TREATMENT CENTRE AND/OR HOSPITAL(S) DOES YOUR CHILD GO TO - PLEASE LIST:</b>			
_____			

## SECTION THREE: SERVICES REQUESTED

(TO BE COMPLETED BY PARENT/GUARDIAN)

<b>INDICATE WHICH SERVICES YOU WOULD BE INTERESTED IN RECEIVING / PARTICIPATING IN FROM EASTER SEALS ONTARIO:</b>	
<input type="checkbox"/> Financial Assistance	<input type="checkbox"/> Camping
<input type="checkbox"/> Easter Seals Ontario e-newsletter – email: _____	<input type="checkbox"/> Special Education Information
<input type="checkbox"/> Information on local Events/Activities (Regatta, Christmas Party etc) – please contact me via: <input type="checkbox"/> e-mail <input type="checkbox"/> 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 FURTHER 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.

<b>DIAGNOSIS (PLEASE BE SPECIFIC):</b>	
<b>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.</b>	
<b>OVERVIEW OF GROSS MOTOR FUNCTIONS – CAN THE CHILD:</b>	
<b>Roll?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	<b>Sit?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
<b>Stand?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	<b>Walk?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
<b>Walk with Assistance:</b> How far independently? _____	
<b>Type of assistance:</b> Hand Holding? <input type="checkbox"/> No <input type="checkbox"/> Yes Equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Holding on to objects? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Climb stairs?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance	<b>ADL's?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
<b>IF APPLICABLE PLEASE SELECT THE GROSS MOTOR FUNCTION LEVEL?</b>	
<input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV <input type="checkbox"/> 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? If with assistance please give a detailed description: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
Does the child walk in his/her immediate environment at school? If with assistance please give a detailed description: _____		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> With assistance
Does the child have orthotics?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What type of orthotics? _____
If yes, are they ADP funded?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Will they be required long term? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unable to determine
Does the child have a stroller?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, is it ADP funded?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Will it be required long term? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unable to determine
Will the child need long term mobility equipment in the future?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unable to determine
If yes: <input type="checkbox"/> within 6 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> Longer		
<b>****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 <u>NOT</u> BE COMPLETED AT THIS TIME.****</b>		

### FOR ALL AGES - DOES THE CHILD HAVE:

G-tube / J-tube:	<input type="checkbox"/> No <input type="checkbox"/> Yes – type: _____	Seizures:	<input type="checkbox"/> No <input type="checkbox"/> Yes – type: _____
Tracheostomy:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Shunt:	<input type="checkbox"/> No <input type="checkbox"/> Yes – type: _____
Ventilator:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Impaired Hearing:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Verbal Skills:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Limited	Impaired Vision:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Incontinent:	<input type="checkbox"/> No <input type="checkbox"/> Yes *		
*If yes, please visit <a href="http://www.easterseals.org">www.easterseals.org</a> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Being used for all mobility outside of the home? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Being used for long distance only? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Being used for safety so child is not able to run away? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Being used for transportation to school? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Being used within the school? <input type="checkbox"/> No <input type="checkbox"/> Yes
Manual Wheelchair	Is this the child's first ADP funded stroller? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Can child propel own chair? <input type="checkbox"/> No <input type="checkbox"/> Yes
Power Wheelchair	Is this the child's first ADP funded wheelchair? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Is this the child's first ADP funded power wheelchair? <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes: From where?
Walker	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Stander	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Braces (AFO/KAFO)	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
Oxygen	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bath/Shower Aids	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed
Communication Device	<input type="checkbox"/> No <input type="checkbox"/> Yes – if yes, is it ADP funded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Being assessed- if selected, will it meet ADP criteria? <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>DOES THE CHILD HAVE THE FOLLOWING? CHECK (✓) ALL THAT APPLY</b>	
<input type="checkbox"/> Porch Lift <input type="checkbox"/> Van Lift <input type="checkbox"/> Track Lift <input type="checkbox"/> Stair Lift <input type="checkbox"/> Portable Lift <input type="checkbox"/> Ramp	

### THERAPIST INFORMATION:

Name: _____	<input type="checkbox"/> OT <input type="checkbox"/> 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](mailto: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](mailto: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.