Easter Seals Ontario
Helping Kids with Physical Disabilities Succeed

Guidelines for the Slaight Family Foundation Hospital Bed Funding Program

Easter Seals Ontario has been granted a multi year grant from the Slaight Family Foundation to provide a hospital bed and specialized mattress funding program. This will be the second year of an annual time limited program.

The program will provide funding towards a single sized hospital bed with a basic mattress or a specialized mattress. Priority will be given to those who have no hospital bed or specialized mattress. The funding does not extend to cribs, enclosed cribs/enclosed bed systems or purchased hospital beds or specialized mattresses.

Guidelines:

- To be eligible for this program, the applicant must be registered with Easter Seals Ontario, under the age of 19 years and have a valid Ontario Health Card.
- This funding is not included in the annual $3,000 limit of Easter Seals' Financial Assistance Program.
- The request for Financial Assistance must be submitted and a response must be received prior to the hospital bed, specialized mattress being ordered or received
- Vendor must be located in Ontario
- If any information is missing or incomplete, the application will not be reviewed
- Labour/installation, taxes, delivery or assessment costs are not funded
- Current quote and letters of support from a health professional(i.e. occupational therapist or physiotherapist) must accompany this application
- Applicant must complete the authorization to release information stating the vendor to whom Easter Seals is to release the notification of approved funding
- Applicant must initial that he/she has not ordered or received the single sized hospital bed, specialized mattress
- The completed application must be signed and dated
- Funding approval is valid for 4 months from the date of approval. The invoice from the vendor must be received prior to the end of the 4 month period
- If an invoice is received and the date of the delivery is noted to be prior to approval given by Easter Seals Ontario, then it is not eligible for Easter Seals funding. Funding approval will not be considered to be valid and the parent will be responsible to pay the full amount to the vendor.
- Parents are responsible to order the equipment after an approval letter has been received from Easter Seals Ontario. Parents must sign and date the invoice upon receiving the equipment. Once the item has been received, Easter Seals payment will be paid to the vendor directly. No funds will be paid directly to the parent.

Please Note: this program is being offered commencing June 1, 2017 and will close once all funds have been distributed. This specific program is not part of Easter Seals' Financial Assistance Program

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Slaight Family Foundation
Hospital Bed Funding Program Application Form

Parent Name: _____ **Date of Request:** _____
Last Name, First Name Month, Day, Year

Address: _____

City: _____ **Postal Code:** _____

Telephone Numbers: Home: ( )_____ Work: ( )_____

Parent E-mail Address: _____

Child's Name: _____ **Date of Birth:** _____
Last Name, First Name Month, Day, Year

Diagnosis: _____

Have you received Easter Seals' funding previously? □ Yes □ No

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 ❒ Over $180,001

Equipment/Item Requested: _____
Please specify – name of equipment

Estimated Cost of Equipment/Item: _____

Vendor MUST be in Ontario
Vendor: 1. _____
Name of Vendor

Other funding sources you accessed:

Employer Extended Health Care Benefits ☐ Yes ☐ No ☐ N/A Other Agencies: ☐ Yes ☐ No ☐ N/A

If yes, please list : _____

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Calculation of Request for Financial Assistance:

Please complete by inserting funds received from other funding sources

A) Estimated Cost of Equipment/Item _____

Write in Amount from Preferred Vendor Quote

B) Employer Extended Health Care Benefits _____

Write in Amount

C) Other Agencies _____

Write in Amount (if Applicable)

D) Total Remaining _____

Line A – B – C = D

TOTAL REQUESTED FROM EASTER SEALS _____

I instruct and authorize Easter Seals Ontario to provide and release any information to _____ after Easter Seals Ontario has approved funding for the equipment being requested in this application. **(Name of Vendor)**

I understand that no information will be released without my authorization. I understand and agree that 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 inquiries may require exchange of information that may take the form of electronic data exchanges.

I certify that the information provided in the application is true, correct, and complete to the best of my ability and that the equipment has NOT been received. If you have received the requested piece of equipment you are NOT eligible to apply to Easter Seals for funding. **Please initial that you have read and understand the above statement and are NOT in possession of the requested equipment.** ☐

I will indemnify and save harmless Easter Seals Ontario its employees from and against any and all expenses related to all claims, demands, liabilities, losses, costs, damages, actions, suits or other proceedings of any nature or kind whomsoever sustained, brought or prosecuted in any manner based upon, occasioned by or attributable to the negligent act or omissions or the willful or reckless misconduct of the vendor/contractor, in the fulfillment of utilizing the funds provided by Easter Seals Ontario. Easter Seals Ontario acts as a third party funder and as such has no role in prescribing, recommending equipment, selecting a vendor/contractor and in the relationship between the parent and vendor. Payment from the Financial Assistance Program is not an acknowledgement that the work or equipment was acceptable.

If approved to receive funding, I agree to have an Easter Seals staff person contact me, to provide a testimonial about the difference having the hospital bed & or sleep system has made to my child. ❒ Yes ❒ No

Parent's Signature: _____ Date: _____

Please review this form to ensure all information and supporting letters/documentation is provided. If any information is missing, the application will not be reviewed. Please keep a copy of the completed form for your files.

Completed Applications can be sent via:

Mail: Financial Assistance Program, Easter Seals Ontario, 700-1 Concorde Gate, Toronto, Ontario M3C 3N6
Fax: 416.696.1035 (please send to Attention: Financial Assistance Program)
E-mail: services@easterseals.org

Please note, it is the parent/guardian(s) responsibility to follow up with Easter Seals to ensure the application has been received. Questions? Contact the Financial Assistance Program at 416.421.8146, toll free at 1.866.630.3336 or at services@easterseals.org.

Application Check List: ensure you include:

- Completed application
- Current Quote
- Letter of Support from OT or PT