



**Toronto Chapter**  
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## Funding Program Application

Applying for:      Air Conditioning       Equipment       Home Help       Incontinence Supplies

*First time applicants - please provide proof of diagnosis from your family physician or neurologist.*

### PART 1 – APPLICANT’S PERSONAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone #: \_\_\_\_\_      Alternate phone #: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Membership:    Current       New/Renewal       \$15 annual membership fee enclosed

|                          |                                      |                                      |
|--------------------------|--------------------------------------|--------------------------------------|
| Source of family income: | Applicant:                           | Spouse/Partner:                      |
|                          | Employed <input type="checkbox"/>    | Employed <input type="checkbox"/>    |
|                          | CPP <input type="checkbox"/>         | CPP <input type="checkbox"/>         |
|                          | Pension <input type="checkbox"/>     | Pension <input type="checkbox"/>     |
|                          | ODSP <input type="checkbox"/>        | ODSP <input type="checkbox"/>        |
|                          | LTD <input type="checkbox"/>         | LTD <input type="checkbox"/>         |
|                          | Other <input type="checkbox"/> _____ | Other <input type="checkbox"/> _____ |

Type of residence:    House     Supportive housing     Apartment/condo     Long-term care

Can you speak English?    Yes     No       Can you read English?    Yes     No

Other languages: \_\_\_\_\_

### PART 2 – MEDICAL INFORMATION

Year diagnosed: \_\_\_\_\_

Type of MS:      Primary progressive       Secondary progressive       Relapsing-remitting

Family physician: \_\_\_\_\_      Phone: \_\_\_\_\_

Neurologist: \_\_\_\_\_      Phone: \_\_\_\_\_



### PART 3 – RELEASE OF INFORMATION

The Multiple Sclerosis Society of Canada, Toronto Chapter, protects the privacy of our clients. The information collected is used to provide services to clients, information about programs and meetings, and to compile anonymous statistical information. In relation to this application, information is shared with authorized individuals and companies outside the MS Society of Canada on a need to know basis only if a release of information is signed by the client. By signing below, you hereby consent to the collection, use and disclosure of this information by the MS Society of Canada as it relates to your application.

I \_\_\_\_\_ hereby give my permission to the Multiple Sclerosis Society of Canada,  
*Print name*

Toronto Chapter to release pertinent personal information including personal health information currently on file. I wish to place the following restrictions on the release of this information:

\_\_\_\_\_  
**Client Signature/Mark:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*The Multiple Sclerosis Society of Canada complies with the Personal Information Protection and Electronic Documents Act. If you have any questions about your personal information, please contact our privacy officer, Patricia Cole, at 416-967-3036. A copy of our privacy policy may be obtained at any MS Society office by calling 1-800-268-7582 or at [www.mssociety.ca](http://www.mssociety.ca).*

**IF APPLYING FOR:**

- Air conditioning – please complete part 4.**
- Equipment – please complete part 5.**
- Home help – please complete part 6.**
- Incontinence supplies – please complete part 7.**

### PART 4 – AIR CONDITIONER REQUESTS ONLY

Size of window: \_\_\_\_\_

Size of room: \_\_\_\_\_

### AIR CONDITIONER RELEASE

In applying to the Toronto Chapter of the MS Society of Canada for assistance in obtaining an air conditioner, I agree that the MS Society of Canada is not responsible for any damages, claims or causes of action that might arise with respect to the air conditioner once it is delivered. I will keep this air conditioner in good condition and safe working order, in accordance with the original manufacturer's specifications. I accept responsibility for any costs associated with the ongoing maintenance of the air conditioner. By signing below, I agree to these terms.

**Client Signature/Mark:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PART 5 – EQUIPMENT REQUESTS ONLY

Loans cupboard  and/or Funding request

Equipment required: \_\_\_\_\_

**For funding requests**, please complete the following chart and submit one quote for ADP funded items and two quotes for non-ADP funded items. Applicants must explore all available resources, including their own. We ask applicants to contribute whatever they can afford.

| Funding Resources                               | Eligible for funding?<br>(Y/N) | Application sent?<br>(Y/N) | Amount (\$)<br>(if known) |
|---|--------------------------------|----------------------------|---------------------------|
| Applicant/family contribution                   |                                |                            |                           |
| Assistive Devices Program (ADP)                 |                                |                            |                           |
| Ontario Disability Support Program (ODSP)       |                                |                            |                           |
| Special Needs Unit or Hardship Fund             |                                |                            |                           |
| Ontario March of Dimes                          |                                |                            |                           |
| Extended health care/insurance                  |                                |                            |                           |
| Other (community agencies, service clubs, etc.) |                                |                            |                           |

### **HEALTH CARE PROFESSIONAL** - *Occupational therapist or physiotherapist*

A detailed written assessment must be attached to support equipment requests. The following information about the applicant is required:

- Family and home support
- Functional limitations (physical and cognitive), safety and mobility concerns
- Applicant's willingness to use equipment
- Results of similar equipment trial, if possible
- Detailed description of recommended equipment (eg. size, height, back, cushion, etc.)

### **EQUIPMENT RELEASE**

In applying to the Toronto Chapter of the MS Society of Canada for assistance in obtaining equipment, I agree that the MS Society of Canada is not responsible for any damages, claims or causes of action that might arise with respect to the equipment once it is delivered. I will keep this equipment in good condition and safe working order, in accordance with the original manufacturer's specifications. I accept responsibility for any costs associated with the ongoing maintenance of this equipment, including the replacement of batteries. By signing below, I agree to these terms.

**Client Signature/Mark:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **PART 6 – HOME HELP REQUESTS ONLY**

This program, which provides a financial subsidy of up to \$55 per month, is intended for members who are not able to maintain their household independently or have family that is not available to provide assistance in this area. Subsidies are provided based on the Toronto Chapter's financial capabilities and may be subject to change.

How many adults live in your household? \_\_\_\_\_

Are they available to assist with some household responsibilities? Please explain.

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## **PART 7 – INCONTINENCE SUPPLIES REQUESTS ONLY**

This program, which provides a financial subsidy of up to \$40 per month, is intended for members who are not receiving any other financial assistance for these supplies (such as ODSP and insurance benefits). Subsidies are provided based on the Toronto Chapter's financial capabilities and may be subject to change.

What supplies do you use? \_\_\_\_\_

What is your average monthly cost of supplies? \_\_\_\_\_