ALS SOCIETY OF ONTARIO
ALS Equipment Program Application Form

Note: Applicants must be diagnosed with ALS and registered with the Society to qualify for assistance.
Please ensure that both sections of this application form are completed and submitted.

Section A: For Applicant, Guardian or Next of Kin

Name of Applicant_________________________________ Date of Birth ___________
Last First Month Day Year

Address: ____
Street City Province Postal Code

Telephone: ______________________________ Email: ______________________________

Alternate Contact Person, if any:
Name: ______________________________
Relationship with applicant: ______________________________
Telephone #: ______________________________

Assessment of Funding Criteria - Private and Confidential

Number of dependents living in the household: _____

Total annual income of applicant and spouse, if applicable (☑);

- ❑ Below $15,000
- ❑ $15,001 - $30,000
- ❑ $30,001 - $60,000
- ❑ $60,001 - $80,000
- ❑ $80,000 +

Please indicate all sources of family income (☑);

- ☐ Salary
- ☐ Employment Insurance
- ☐ Government Pension Plan
- ☐ Worker's Compensation
- ☐ Private Pension Plan
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Other Assistance/Welfare programs or other sources of income: ______________________ (please specify)

If you or your family has medical coverage beyond the basic OHIP plan, please indicate the source and extent of coverage here: ____

Have you applied under the Ontario Disability Support Program (ODSP), Assistive Devices Program (ADP), or to March of Dimes, Veterans Affairs Canada any other organization for assistance? If so, please specify here *(ALS Society of Ontario requires that prior to submitting an application, individuals must exhaust other available funding sources):* ____

Certification

I certify that the information contained in this form is true, correct and complete to the best of my knowledge. I authorize the ALS Society of Ontario to carry out necessary inquiries and obtain or release personal information from/to my health care providers, equipment suppliers and community agencies, for the purpose of confirming or clarifying the information provided and for service delivery purposes.

Terms of Use:

The ALS Society of Ontario requires that individuals contribute their agreed portion toward the cost of purchase or lease of equipment. If an item is loaned from the ALS Society of Ontario Equipment Pool, individuals will be required to pay 100% of the delivery and installation costs directly to the vendor who has delivered and installed the equipment.

For an applicant's initial equipment funding request, we require a copy of the applicant's prior year's household Canada Revenue Agency notice of assessment as proof of income. Once we have the information on file, it will only need to be submitted again if the household income has changed. Please note that this information will be kept confidential as all of our client information is.

In extenuating circumstances, the ALS Society of Ontario may be able to waive or reduce the applicant portion of the funding. A Needs Test *will be required to support their request for additional funding.*

Signature of Applicant (or *legally* authorized representative): ______________________________

Date: ______________________________

ALS SOCIETY OF ONTARIO
Equipment Program Application Form (Page 2)

Section B: To be completed by health care professional

Name of Applicant: ____
Last First

Assessed by: ____
Last First

Professional Designation: ________________________ *Company/Agency:* ________________

Telephone: ____________________ *Fax:* ________________ *Email:* ________________

Note: Prescriptions for seating and positioning needs and mobility aids must be prepared by Occupational or Physical Therapists. Refer to the program information sheet for more details. Please ensure that the equipment prescribed is essential. The ALS Society of Ontario has very limited resources to assist individuals

Details of equipment requested: *Provide measurement/dimensions and relevant specifications for each item requested. Attach additional sheets, if necessary or quotes where appropriate.* **Please print clearly.**

1.

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2.

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For funding requests (purchase, lease or rental), please complete the following table as well:

	(All figures in CAN $)	***Example***	***Equipment*** *Request # 1*	***Equipment*** *Request # 2*	***Total***
1.	Type of assistance required*	*Purchase*			
2.	Total Cost	*3000*			
3.	ADP Funding	*2000*			
4.	Other funding sources	*NIL*			
5.	Client Cost [(2) - (3+4)]	*1000*			
6.	Funding Requested (max. 65% of Client Cost):	*650*			

Mention purchase, lease or rent as applicable.* ***If the requested item is available in our Equipment Loan Pool, it will be loaned rather than purchased.* *Appropriate documentation (copy of approval from ADP, quotation/invoice etc.) must be attached with requests for purchase assistance.*

List other applications made for funding for this equipment (i.e. ADP, ODSP, CCAC, Homecare, Red Cross, Service Clubs, etc.): ____

Certification - to be signed by the health care professional

I certify that the information contained in this form is true, correct and complete to the best of my knowledge.

Signature: ______________________________ **Date:** ____________________

Please attach page 1 (client information and funding criteria) and mail or fax the completed form to:

ALS Society of Ontario
402-3100 Steeles Ave E, Markham, ON L3R 8T3
Phone: 905-248-2101 or 1-866-611-8545 Fax: 905-248-5620