APPLICATION FOR FINANCIAL ASSISTANCE

Funding Criteria:

- Child must be no older than 18 years of age & reside in North Durham Region (Brock, Scugog, Uxbridge Townships).
- Funds may be provided for extra costs to the family to contribute to the healthy development of the child and relieve related financial stress on families who have children with barriers to learning.
- The approval of funding will be at the discretion of the Funds Committee and money will be payable to the agency or person providing the service.
- Precious Minds will only provide funding for up to 50% of the family contribution to the equipment/service.
- Further documentation may be required by the Funds Committee to make a decision.
- Funding approval is valid for six months from date of the agreement to provide funding support.

Child's Name: _____ _____ Date of Birth:_____
LAST NAME FIRST NAME YYYY/MM/DD

Parent/Guardian: _____ _____ Relationship: _____
LAST NAME FIRST NAME

Address: _____
STREET NAME, CITY PROVINCE POSTAL CODE

Telephone No.: _____ _____ Email Address: _____
HOME WORK/CELL

Child's Diagnosis: _____

Have you previously received funding from us? Yes No Year: _____

List the equipment or service for which financial assistance is being requested:

Equipment or service: _____

Proposed equipment/service provider: _____

Total cost of equipment/service: $_____

Please describe the specific purpose for these funds: _____

_____

_____

*Applications must be accompanied by a quote from the equipment/service provider that states the total cost of the equipment/service to be provided, and the amount to be paid by the family. If approved, an invoice must be provided to Precious Minds.

Referral Information

Is this service/equipment needed on the basis of a referral by:

Physician Yes No

Registered Health Professional

(Speech Pathologist/Occupational Therapist/Physical Therapist): Yes No

If yes, please provide name and phone number: _____

Is this service/equipment being accessed on the basis of a recommendation by a school board professional? Yes No

If yes, please provide name and position/school: _____

Are you currently receiving support from other community agencies Resources for Exceptional Children, Durham Infant Development) Yes No

If yes, please provide name and phone number: _____

Other funding sources you have accessed:

Employer Extended Health Care Benefits:	Yes	No	Amount of funding: $ _____
Other: ADP (Assistive Devices Program)	Yes	No	Amount of funding: $ _____
ACSD (Assistance for Children with Severe Disabilities)	Yes	No	Amount of funding: $ _____
SSAH (Special Services at Home)	Yes	No	Amount of funding: $ _____
Other: _____	Yes	No	Amount of funding: $ _____

For purposes related to processing this application, I agree that Precious Minds may:

- Contact equipment/service providers
- Contact professionals who have referred equipment/service for my child
- Contact me to provide further clarification or documentation.

I _____ agree with the above and acknowledge that I have read the guidelines for Financial Assistance. I certify that the information provided in this application is true, correct and complete to the best of my ability and the equipment/service has not yet been received.

Parent/Guardian Signature: _____ Date: _____

Office Use Only

Received: _____ Approved: _____

DATE INITIALS YES/NO DATE INITIALS

Communicated to Parent/Guardian: _____

PHONE/EMAIL DATE INITIALS

Calculation of Request for Financial Assistance

A) Estimated Cost of Equipment/Service: $_____
TOTAL AMOUNT OF PROVIDER QUOTE

B) Other Funding: $_____
AMOUNT OF BENEFITS/OTHER FUNDING

C) Parent Contribution: $_____
LINE A – B X 50% = C

D) Total Remaining: $_____
LINE A – B – C = D