Save Print

Direct Funding Application Form

Before starting this application, have you…

☐ reviewed the eligibility criteria? (Pages 1 – 2 of the Application Guide)
☐ contacted your local Independent Living Resource Centre for assistance?
☐ reviewed the Application Guide? (You will find the Guide necessary while completing the application)

You must:

- Complete this form in your own words (someone may assist you to record your responses)
- Use black pen or a printer
- You must send an original signed hard copy of your application, no emails, faxes or photocopies. Please keep a copy for your records.

LEGAL NAME*:_____

*Are you known by any other names? ☐ No ☐ Yes If yes, please provide:_____

ADDRESS:_____

CITY:_____ POSTAL CODE:_____

PHONE:_____ / _____ / _____
(HOME) (MOBILE) (WORK)

EMAIL:_____ How would you like us to contact you?_____

ALTERNATE CONTACT:_____ / _____
(NAME) (PHONE NUMBER)

1. Ontario Health Card No.: _____

2. Date of Birth (DD/MM/YY):_____ 3. Gender: _____

4. Name of permanent physical disability/ disabilities:_____

_____

5. Please CHECK OFF each activity for which you require attendant services:

☐ Turning in bed, ☐ lifting, ☐ positioning or ☐ transferring;
☐ Washing, ☐ bathing, ☐ showering, ☐ shaving or ☐ personal grooming;
☐ Dressing or ☐ undressing;
☐ Catheterization, ☐ emptying and changing a leg bag, ☐ using the toilet, ☐ urination or ☐ bowel routines;
☐ Breathing, ☐ caring for a tracheotomy or ☐ respiratory equipment;
☐ Eating/being fed;
☐ Meal preparation, ☐ dish washing, ☐ laundry or ☐ other housekeeping tasks;
☐ Assistance with essential communication.

6. Do you have a communication disability? If yes, how do you communicate with others? Please describe:

_____

_____

7. Has your need for assistance with the activities in Question 5 changed within the last year? If yes, please describe:

_____

_____

8. Living arrangements: ☐ alone ☐ with family/others

9. (a) Please CHECK OFF your current sources of attendant services, funding, or other services that assist you with activities of living:

- ☐ Personal Support Services/Homemaking Services arranged through LHIN (Local Health Integration Network) e.g., Homecare, homemaking
- ☐ Attendant Outreach Services
- ☐ Supportive Housing (Important: see DF Application Guide, page 3)
- ☐ Long-term care facility (nursing home, or other health care residential facility)
- ☐ Rehabilitation facility
- ☐ Transitional living
- ☐ Insurance settlement, insurance payments, private health plan
- ☐ Other (e.g., family, etc)

10. For the sources you have checked off above, provide the ORGANIZATION'S NAME, PHONE NUMBER AND CONTACT PERSON. This will enable us to verify your current services:

_____

_____

10. Do you have, or do you expect to receive, any insurance settlement or payments, private health plan, WSIB or other similar funds? (You are legally required to provide full disclosure.)

☐ Yes ☐ No Please describe: _____

_____

11. Please indicate how many hours you use from EACH AND EVERY source you identified in Question 9, including family. Multiply weekly amount by 4.33 to calculate your monthly total.

Source	Weekly	Monthly (Weekly x 4.33)
Total Hours per month:		

12. Your Proposed Service Plan: Consider your daily routines as they would be on Direct Funding. List the major activities for which you would schedule an attendant. Enter the time required, in hours. (Use decimals for partial hours: 0.25 for ¼ hour, 0.5 for ½ hour and 0.75 for ¾ hours).

(a) MORNING ASSISTANCE:_____

_____

Mon.___ Tue.___ Wed.___ Thu.___ Fri.___ Sat.___ Sun.___

Add Up: Monday through Sunday hours MORNINGS – WEEKLY SUBTOTAL _____(1)

(b) DAY/EVENING ASSISTANCE (including lunch, dinner):_____

_____

Mon.___ Tue.___ Wed.___ Thu.___ Fri.___ Sat.___ Sun.___

Add Up: Monday through Sunday hours DAY/EVENING – WEEKLY SUBTOTAL _____(2)

(c) NIGHT-TIME ASSISTANCE (including bedtime):_____

_____

Mon.___ Tue.___ Wed.___ Thu.___ Fri.___ Sat.___ Sun.___

Add Up: Monday through Sunday hours NIGHT-TIME – WEEKLY SUBTOTAL _____(3)

Add Up: lines (1), (2) and (3) TOTAL OF WEEKLY AMOUNTS _____(4)

Multipy: line (4) by 4.33 = MONTHLY SUBTOTAL _____(5)

(d) OCCASIONAL ASSISTANCE INVOLVING EXTRA HOURS: Add the average monthly times not already included in 12. (a), (b), (c).

(**Important**: See **Direct Funding Application Guide**, page 7): _____

_____

OCCASIONAL ASSISTANCE MONTHLY SUBTOTAL _____(6)

Add Up: lines (5) and (6) TOTAL MONTHLY HOURS _____(7)

(**Note**: Line (7) should not exceed 212.2 hours.)

13. Determine your **Monthly Budget Calculation** as follows:

(a) OPTIONAL ARRANGEMENTS COST (if needed)
Please CHECK OFF each arrangement you require, show cost and calculation (averaged monthly):

❑Overnights, ❑attendant travel to work, ❑emergency/back-up.....= $_____(8)
SHOW YOUR CALCULATION (e.g., 5 overnights/month @ $50.00/each =$250.00):

_____

❑Agency services or ❑other fees not paid to your attendants……..= $_____(9)
SHOW YOUR CALCULATION: _____
Add Up: lines (8) and (9) ➢ OPTIONAL ARRANGEMENTS MONTHLY COST = $_____(10)

(b) REGULAR MONTHLY WAGES
Total Monthly Hours: From line (7) .....= _____(11)
Average Wage Cost per Hour .....= $ 19.00 (12)
Multiply: line (11) by line (12) ➢ REGULAR MONTHLY WAGES = $ (13)

(c) EMPLOYER'S PORTION OF MERCS AND BENEFITS
Add Up: lines (8) and (13): Total of Employees' Earnings .....= $_____(14)
Multiply: line (14) by 18% ➢ EMPLOYER'S PORTION OF MERCS AND BENEFITS = $_____(15)

(d) MISCELLANEOUS EXPENSES*
Bookkeeper/Payroll Services (monthly average) ..... = $ 170.00 (16)
Advertising, Postage, etc. (monthly average) ..... = $ 25.00 (17)
Bank Charges (monthly average) ..... = $ 10.00 (18)
Liability Insurance Portion (monthly average) ..... = $ 10.00 (19)
Add Up: lines (16), (17), (18) and (19) ➢ MISCELLANEOUS EXPENSES = $ 215.00 (20)

Add Up: lines (10), (13) 15) and (20) ➢ **TOTAL MONTHLY BUDGET** = $_____(21)

(e) CONTINGENCY AMOUNT
Multiply: line (21) by 5% ..... = $_____(22)

*Miscellaneous expense funds are intended for payments to third parties only.

14. (Optional) In the space below, or on a separate page, please describe any strengths, experiences and/or training which demonstrate your ability to be a self-manager of attendants.

15. How did you hear about Direct Funding?

16. Declaration

I have read and understand the General Information Booklet and the Application Guide. I am prepared to undertake the functions, responsibilities and possible risks of being an employer of my own attendants.

I understand and accept that I will be interviewed and questioned about my disability, past and current services and any other aspects of my application. I hereby confirm that the above information is true and accurate and that this application has been prepared by me.

_____

(APPLICANT'S SIGNATURE OR MARK*) (DATE MM/DD/YYYY)

***Please note**: This application MUST BE signed or marked **by the applicant him/herself**. Signatures from family members or persons designated with Power of Attorney will not be accepted.

17. Attachments and mailing instructions

Please send in your ORIGINAL, signed application. If you have filled it out in PDF format, please print it out to sign and send. Be sure to **keep a copy for your records.**

Remember to include:

❑ "Release of Information Request Form" (page 6)

MAIL THE ORIGINAL APPLICATION TO:

Centre for Independent Living in Toronto (CILT), Inc.,
Direct Funding Program,
365 Bloor Street East, Suite 902
Toronto ON M4W 3L4

This form is confidential when received by CILT. (see next page) ➢

RELEASE OF INFORMATION REQUEST FORM

To Whom It May Concern:

This is to certify that I, _____, (Applicant's full name)
[Please print]
am an applicant to, or am a Participant in, the Self-Managed Attendant Services – Direct Funding Program (the "Program") administered by the Centre for Independent Living in Toronto (CILT), Inc.("CILT") .

This will serve to authorize any provincial, federal, or municipal government ministry, agency or body; any financial institution; any attendant service provider or any health care provider who has knowledge, information, or documentation pertaining to my disability, my application to, or my participation in, the Program to release said information to, and/or discuss said information, documentation or any related matter with, CILT's Executive Director or Direct Funding Program Manager or any other person whom they may delegate to receive such information or documentation. I acknowledge that CILT might, for example, confirm my needs with other attendant service providers or health care providers. Any such information and/or documentation is collected for the purpose of evaluating my needs and/or participation in the Program and shall be kept in strict confidence within CILT and not be disclosed unless written permission is given to do otherwise.

This will save harmless any provincial, federal, or municipal government ministry, agency or body; any financial institution; any attendant service provider or any health care provider from any action or result from releasing such information or documentation.

This shall be sufficient authority for so releasing the above-mentioned personal information to CILT, as required by the federal Access to Information Act, the provincial Freedom of Information and Protection of Privacy Act. and the Personal Health Information Protection Act (PHIPA). I acknowledge that CILT, as a health information custodian, collects and retains my personal health information in accordance with PHIPA and may only use this information for the purpose of evaluating my needs and/or participation in the Program .

Thank you for your co-operation in this matter. Please send all correspondence to:

Direct Funding Program Manager
Centre for Independent Living in Toronto (CILT), Inc.
365 Bloor Street East, Suite 902
Toronto, Ontario M4W 3L4

phone: (416) 599-2458
1-800-354-9950
fax: (416) 599-3555

_____ _____

(Applicant or Participant) Signature or Mark Date (MM/DD/YYYY)

_____ _____

(Witness) Signature or Mark Date (MM/DD/YYYY)

Office Use Only

_____ _____

(Direct Funding Program) Signature or mark Date (MM/DD/YYYY)