Active Living
Assistive Devices
Family & Community Support

# Easter Seals Nova Scotia Assistive Devices Funding Request for 2018

**Funding limit is $500 maximum – one application per year. Payment is only provided directly to the supplier. If a refurbished item in good condition is available at Easter Seals, it may be provided instead of funding.**

→ Funding **will not** be provided for purchase of: wheelchairs, scooters, ramps, beds or mattresses, vision-related devices, vehicle hand controls, vehicle customization, travel expenses, hearing aids for adults. Items already ordered or purchased will not be considered for funding.
- Communication devices for children who are non-verbal will be considered.

**→When submitting this application, the following documents are required:**

- ☐ **an occupational therapist/physiotherapist health care professional prescription pertaining to the equipment needed,**
- ☐ **2 quotes from retail equipment suppliers for medical equipment needed,**
- ☐ **provide family's last year's Canada Customs Revenue Notice of Tax Assessment showing net income. (see page 2 Income section)**

→Applicant Information: **Birth Date** (Yr/Month/Day): ____________

Name: ____________

Address: ____________ **Community** ____________

Postal Code: ____________ Phone No. ( ) ____________

If under 18, give parents' names: ____________

**→To be completed by an Occupational or Physio therapist:**

****Item Required:** ____________

**Client Medical Diagnosis:** ____________

Health Care Professional Name: ____________

Tel. No. ____________ Fax No. ____________ ____________
(OT/PT Signature)

Email Address: ____________ Date: ____________

**INCOME:***

Excluding applicant, indicate number of dependent children at home: _______

**For adult application: *Attach Applicant's, & spouse's** *(if applicable), past year's Canada Custom Revenue Agency Notice of Tax Assessment*

**For child's application: *Attach both parent(s)/guardian(s)** *(if applicable) Canada Custom Revenue Agency Notice of Tax Assessments*

If you have a Dept. of Community Services case worker, please provide name and contact.______________________________ ______________

Name | Telephone Number

If you have private insurance, please provide name, (Blue Cross, Maritime Medical,etc) and amount of coverage.

______________________________ $____________

*We appreciate that a personal financial contribution towards your item may not be possible, but any contributions you or others (charity/business/individual)* can make towards the cost of your item will allow Easter Seals Nova Scotia to *assist more individuals.*

NOTE: If the application is approved, a letter is sent to applicant, as well as the licensed supplier.

---

I hereby authorize Easter Seals Nova Scotia (formerly known as Abilities Foundation of Nova Scotia to conduct such enquiries, as it may deem necessary, including contact with insurance providers or other referees. I hereby authorize such agencies, insurance providers or other referees to release information pertinent to my financial affairs. I understand all information presented here will be held in the strictest of confidence by Easter Seals Nova Scotia and only used for statistical purposes.

______________________________

Signature of applicant/parent/care giver

______________________________

Verbal Agreement provided to Prescribing Health Professional by the applicant

**Return form with required documents to**:

Easter Seals Nova Scotia Assistive Devices Funding Program, 3670 Kempt Road, Halifax NS B3K 4X8, Or fax to: 902-454-6121. For further information, contact 902-453-6000, ext. 229 or email: wheelchairs@easterseals.ns.ca