



Direct Funding Application Form

Use the **Direct Funding Application Guide** to complete your application. Submit the original form (no faxes!), and use a **black pen or typewriter**.

Please note: You must complete this in your own words. Physical assistance may be used to record your responses, but professionals, family members or others may not make submissions on your behalf.

This form is confidential when complete.

NAME: _____ POSTAL CODE: _____

ADDRESS: _____ CITY: _____

PHONE: _____

(HOME)

(BUSINESS)

(FAX)

(E-MAIL)

1. Ont. Health Card No.: _____ 2. Date of birth: _____ Age: _____

3. Sex: ___ female ___ male 4. Disability: What is the name of the disability that is the reason you require attendant services? _____

5. Living arrangements: ___ alone ___ with family/others

6. What is your first language/ethnocultural background? (optional) _____

7. Please UNDERLINE 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, or caring for a tracheotomy or respiratory equipment;
- Eating/being fed;
- Meal preparation, dish washing, laundry or other housekeeping tasks;
- Essential communication.

8. Has your need for assistance changed over the last year? If yes, please describe.

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

- Attendant Outreach Services
- Support Service Living Unit (SSLU)/Supportive Housing (**Important:** see **Direct Funding Application Guide**, page 3)
- Insurance settlement, insurance payments, private health plan
- Personal Support Services/Homemaking Services arranged through Community Care Access Centres (e.g., Homecare, homemaking, VON, St. Elizabeth)
- Transitional-living or rehabilitation facility
- Chronic care hospital or long-term care facility (nursing home, or other health care residential facility)
- Other (i.e., none, family, etc.) _____

9. (b) For the sources you have checked off above please specify, where applicable, 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, Workplace Safety and Insurance, or other similar funds? (Note: You are legally required to provide full disclosure.)

___ Yes ___ No Please describe: _____

11. Please indicate the number of HOURS PER MONTH you currently use from EACH of the sources you identified in question 9 (Note: Multiply weekly amount by 4.33 for monthly total.).

_____ : _____ hours/month

_____ : _____ hours/month

_____ : _____ hours/month

TOTAL HOURS PER MONTH: _____

12. Proposed Monthly Attendant Services: List the major activities for which you would hire an attendant. Enter the TIME, IN HOURS, Monday through Sunday. Use decimals for amounts of less than an hour (e.g., use 0.5 instead of 1/2 hour).

(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)

Multiply: 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 6): _____

OCCASIONAL ASSISTANCE MONTHLY SUBTOTAL _____ (6)

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

(Note: Line (7) should not exceed 182.5 hours.)

13. Determine your Monthly Budget Calculation as follows:

(a) OPTIONAL ARRANGEMENTS COST

Please UNDERLINE arrangement, show cost and calculation method (averaged monthly):

• Attendant sleepovers, on-call, attendant travel to work, emergency/back-up..... = \$ _____ (8)

SHOW YOUR CALCULATION (e.g., 5 sleepovers/month @ \$25.00/each =\$125.00):

Agency services, pager rental, 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 = \$ 15.30 (12)

Multiply: line (11) by line (12) ➤ REGULAR MONTHLY WAGES = \$ _____ (13)

(c) EMPLOYER'S PORTION OF M.E.R.C.S AND BENEFITS

Add Up: lines (8) and (13): Total of Employees' Earnings..... = \$ _____ (14)

Multiply: line (14) by 16% ➤ EMPLOYER'S PORTION OF M.E.R.C.S AND BENEFITS = \$ _____ (15)

(d) MISCELLANEOUS EXPENSES

Bookkeeper/Payroll Services (monthly average) = \$ 161.43 (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 = \$ 206.43 (20)

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

(e) CONTINGENCY AMOUNT

Multiply: line (21) by 5%..... = \$ _____ (22)

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. (Important: See **Direct Funding Guide**, page 10.)

15. Declaration

(a) I understand and am prepared to undertake the functions, responsibilities and possible risks of being an employer of my own attendants.

Yes No

(b) 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:

16. Attachments and Mailing Instructions

Please be sure you have included the following attachments (✓):

Supporting documentation (related to question 14)

"Release of Information Request Form" (page 6)

PLEASE MAIL THE ORIGINAL APPLICATION TO:

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

(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 administered by the Centre for Independent Living in Toronto (CILT), Inc. (the “Program”).

This will serve to authorize any person; company; corporation; provincial, federal, or municipal government ministry, agency or body; any attendant service provider; any health care provider; or any other person, or organization who has knowledge, information, or documentation pertaining to my situation, my application or my participation in the Program to release said information to, and/or discuss any information, documentation or any related matter with CILT’s Executive Director or Direct Funding Program Manager or any person they may delegate to receive such information or documentation. Any such information and/or documentation shall be kept in strict confidence within the Direct Funding Program unless written permission is given to do otherwise.

This will save harmless any person, government body, organization, or company 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 my representatives, as required by the Federal Access to Information Act, and the Provincial Freedom of Information and Protection of Privacy Act.

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)