



65 rue Brunswick Street, Fredericton, NB, E3B 1G5

Tel: 506-458-8739  
Fax: 506-457-2863  
E-mail: [info@easterseals.nb.ca](mailto:info@easterseals.nb.ca)  
Web: [www.easterseals.nb.ca](http://www.easterseals.nb.ca)

## **APPLICATION TO PERSONAL SERVICES PROGRAM**

Easter Seals New Brunswick is a charitable, non-profit organization, which provides services to disabled children and adults. Through the Personal Services Program, we offer financial assistance for travel and accommodation costs so our clients can attend appointments in another city. We also provide the long-term loan of rehabilitation equipment that is recommended by a therapist or physician. We can also assist in the financing of items from orthopedic footwear to computers or technical aids, if these are required because of a physical disability.

The majority of our funding comes from private donors and service clubs. It is our responsibility to distribute their gifts as wisely as possible. To do that, we must ask you to provide us with some financial information whenever you request our help for equipment or services. If some other, more appropriate, source of funding is available to you we will help you find it. If no one else can help, we will do our best to provide the service.

We realize that no one enjoys giving personal information. We assure you that your financial statement will be kept strictly confidential. Thank you for your cooperation.

Attached you will find a three-part form to be used when applying to Easter Seals New Brunswick Personal Services Program.

- Section I - identifies the applicant
- Section II - describes the applicant's financial resources
- Section III - Health Professional's Recommendation

Please have a health professional complete Section III first. Then fill out Sections I and II, and mail the application to:

Easter Seals New Brunswick  
Personal Services Program  
65 Brunswick Street  
Fredericton, NB  
E3B 1G5

Please retain this copy for your records  
Revised March 2000.



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## SECTION I- Applicant

**Please complete all questions in order to help us serve you.**

Applicant's Name: \_\_\_\_\_  
*\*If applicant is a child, please use child's name*

Date of Birth: \_\_\_\_\_  
(YY/MM/DD)

Medicare #: \_\_\_\_\_

Application Date : \_\_\_\_\_  
(YY/MM/DD)

Address : \_\_\_\_\_  
*Street Address*

City : \_\_\_\_\_ Postal Code : \_\_\_\_\_ Telephone : \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: same as above \_\_\_\_\_ or

\_\_\_\_\_  
*Street Address*  
City : \_\_\_\_\_ Postal Code : \_\_\_\_\_ Telephone : \_\_\_\_\_

Employed: Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes", please answer questions below:

Employer (of applicant or parent): \_\_\_\_\_  
\_\_\_\_\_  
*Street Address* \_\_\_\_\_ *Telephone*

Do we have your permission to contact your employer for insurance purposes?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Number of dependants in family: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Disability of applicant: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician's Speciality: \_\_\_\_\_

## Section II - Applicant's Financial Resources

Have you completed this part of the form within the past 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If no, please fill out completely. If yes, fill out changes only.

**MONTHLY INCOME OF FAMILY**

Salary \_\_\_\_\_  
 Family Allowance \_\_\_\_\_  
 CPP/OAS \_\_\_\_\_  
 UI Benefits \_\_\_\_\_  
 Disability Insurance \_\_\_\_\_  
 Disability Pension \_\_\_\_\_  
 Income Assistance \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

**Total Income** \$ \_\_\_\_\_

**MONTHLY EXPENSES OF FAMILY**

Mortgage/Rent \_\_\_\_\_  
 Phone/Electricity \_\_\_\_\_  
 Heat \_\_\_\_\_  
 Food \_\_\_\_\_  
 Clothing \_\_\_\_\_  
 Medical Expenses \_\_\_\_\_  
 Transportation \_\_\_\_\_  
 Insurance \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

**Total Expenses** \$ \_\_\_\_\_

Does the family have any extended medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Company: \_\_\_\_\_ Contract Number: \_\_\_\_\_

Does the applicant have a Health Card? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes": I.D. Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

If the applicant is a child is she/he registered as a *Special Needs* child with the Department of Health and Community Services? Yes \_\_\_\_\_ No \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Is the applicant registered with an organization which serves persons with her/his disability  
 (e.g. Cancer Society, Muscular Dystrophy Association, Heart Foundation, MS Society)  
 Yes \_\_\_\_\_ No \_\_\_\_\_ Please name organization: \_\_\_\_\_

May we pass this request on to another agency which might be more appropriate to serve your needs? *We will not disclose your financial statement.* Yes \_\_\_\_\_ No \_\_\_\_\_

Have you contacted or received assistance from any other agency regarding this request?  
 Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes" give details: \_\_\_\_\_

How much could you contribute to the cost of this item/service: \$ \_\_\_\_\_

I have been consulted and agree with the prescription from my health professional.  
 Date: \_\_\_\_\_ Signature: \_\_\_\_\_



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## Section III - Health Professional's Recommendation

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(YY/MM/DD)

Address: \_\_\_\_\_  
*Street*

City: \_\_\_\_\_ Postal Code : \_\_\_\_\_ Telephone: \_\_\_\_\_

Does the applicant have a Health Card? Yes \_\_\_ No \_\_\_ If "yes": I.D. Number: \_\_\_\_\_

### TYPE OF ASSISTANCE REQUIRED:

Reason for travel: \_\_\_\_\_

1 a) Transportation: car / bus / train / air (please circle)

From: \_\_\_\_\_ To: \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_

b) Maintenance: Meals/day: \$ \_\_\_\_\_ Lodging/night: \$ \_\_\_\_\_

Location: \_\_\_\_\_

*Address*

*\*attach doctor's confirmation of referral*

2. Orthotic / Prosthetic / Orthopedic shoes / lifts (please circle)

Prescribed by: \_\_\_\_\_ *\*attach prescription*

Is there a recommended supplier: \_\_\_\_\_

Address: \_\_\_\_\_

3. Rehabilitation Equipment (include complete ordering information - make, catalogue number, size; if wheelchair - attach prescription)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Diagnosis \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Functional Disability: \_\_\_\_\_

Referring Party: \_\_\_\_\_

*Signature*

*Profession*

*Date*

*Work Address*

*Telephone*

*Street*

*City*

*Postal Code*

**NOTE:** Complete details will enable us to make a prompt decision. Please attach any additional information you believe would be helpful.