CANADIAN DISABILITY RESOURCES

Medical Equipment Recycling Program

CANADIAN LOCATIONS

C.D.R.S. ONTARIO

341 Talbot Street, London,
Ontario, N6A 2R5
Toll Free: 1-(888) 909-8974

C.D.R.S. BRITISH COLUMBIA

4429 Kingsway, Unit 31
Burnaby, BC Canada, V5H 2A1
Phone: (778) 588-0577
Toll Free: 1-(888) 909-8974

Website: www.disabilityresources.ca
Email: info@disabilityresources.ca

Canadian Registered Charity # 832723175RR-0001

CANADIAN DISABILITY RESOURCES
4429 Kingsway #31
Burnaby, British Columbia, V5H 2A1
Phone and Fax 1-888-909-8974

ASSISTANCE APPLICATION FORM & GUIDE

PROGRAMS AVAILABLE AND ELIGIBILITY

PLEASE READ THE INFORMATION BELOW TO
SEE WHICH PROGRAM BEST FITS YOUR NEEDS.

You may be eligible for one or more of the Canadian Disability Resources programs if you

- have a disabling condition confirmed by your physician;
- have a disabling condition which lasts two years or at least one year and is likely to recur;
- require assistance or extra money to meet needs arising from your disabling condition; and
- are financially eligible.

What are the programs available from the C.D.R.S. ?

Canadian Disability Resources Society provides assistance and health related benefits for lower income individuals suffering from a physical disability and or with medical conditions who have extra costs or needs.

There are one basic assistance programs available for disabled individuals:

1. Special needs medical equipment supplies.

OVERVIEW

THE INFORMATION PROVIDED WILL BE USED
TO ASSESS ELIGIBILITY FOR ASSISTANCE.

STEP 1 Fill out the Application Form (Page 2 & 3):

PART A: Information about the Applicant
PART B: Professional Referral - Assesor
PART C: Declaration by Applicant

If you are unable to fill out the form yourself,
have a trusted person fill out the form and sign Part C.1

STEP 2 Sign PART D the Dislaimer Form (Page 4)

STEP 3 Once approved PART E STATEMENT OF INTENT Form

If you are unable to fill out the form yourself, have a trusted person fill out the PART E.1 STATEMENT OF INTENT ON BEHALF OF RECIPIENT Form. (page 6)

If you do not understand any part of the application, please contact Canadian Disability Resources at:

(778) 588-0577
or 1 (888) 909-8974

ASSISTANCE APPLICATION FORM - PART A

OFFICE USE ONLY		OFFICE USE ONLY
DECISION	❑ APPROVED ❑ DENIED	
DATE:	/ /	

Part A - Applicant Form

A.1 PROGRAM APPLICATION FOR :

❑ Medical Assistance Program

NAME:			PHONE:
LAST (FAMILY)	FIRST (GIVEN NAME)	MIDDLE NAME	TELEPHONE / CONTACT #

MAILING ADDRESS:		
STREET ADDRESS	CITY OR TOWN	POSTAL / ZIP CODE

SEX ❑ MALE ❑ FEMALE	SIN / SSN NUMBER	PERSONAL HEALTHCARE NUMBER	BIRTHDAY YEAR	MONTH	DAY

A.2 MEDICAL CONDITION

A.1 - WHAT IS YOUR DISABILITY?

____

____

PLEASE ATTACH ANY OTHER INFORMATION THAT WILL HELP US TO UNDERSTAND YOUR CONDITION.

A.3 REQUIRED ASSISTANCE. (Please be descriptive and specific)

MEDICAL: (specify model, size, design, etc.)

____

____

____

____

____

____

A.4 NET INCOME (tax year must be completed)

APPLICANTS ARE REQUIRED TO PROVIDE TAX RETURN INFORMATION	This information is from my income tax return for the year: ________	Enter your net income Enter the net income of your spouse: TOTAL NET INCOME (Add Line 1 and 2)	Line 1 $________ Line 2 $________ Line 3 $ ________

DECLARATION AND CONSENT

Please read and sign. If you are married or living in a marriage-like relationship, your spouse must also sign the declaration. The information obtained will be relevant to, and will be used solely for the purpose of, determining and verifying eligibility for assistance and will not be disclosed to any other party. This authorization is valid until revoked by me, in writing, to C.D.R.S. I have resided in Canada as a Canadian citizen or holder of permanent resident status (landed immigrant) for at least 12 months immediately preceding this application. I am not exempt from liability to pay income tax by reason of any other Act.

____________________ Signature of Applicant

____________________ Date Signed

____________________ Signature of Spouse

____________________ Daytime Telephone Number

ASSISTANCE APPLICATION FORM - PART B & C

Part B - Professional Referral - CHOOSE AN ASSESSOR

B.1 - CHOOSE A QUALIFIED ASSESSOR TO FILL OUT THIS DELCARATION.
An Assessor is a person who has professional knowledge of your disabling condition and an insight into its effect on your daily living (eg: Physician, social worker, nurse, etc.)

B.2 DECLARATION (Assessor to fill out)

DECLARATION:
I certify that I am a qualified assessor as defined in this application guide.
The assessment I have provided is accurate and unbiased to the best of my knowledge.

NAME (PLEASE PRINT)	TITLE	DATE

X ______________________ SIGNATURE OF ASSESSOR	ORGANIZATION OR FACILITY (if any)	TELEPHONE ( )

?

If you are unsure whether the person you have chosen meets the criteria, please contact:
Canadian Disability Resources:

(778) 588-0577
or
1 (888) 909-8974

Part C -Declaration (Applicant)

A. I DECLARE:
This is my application.
All of the information in it is true and complete to the best of my knowledge and belief.

B. I PERMIT:
Canadian Disability Resources to contact anyone or to obtain a report from any agency to confirm the information I have provided.

X ______________________ ______ / ______ / ______
YEAR MONTH DAY

IF THIS FORM WAS COMPLETED BY SOMEONE OTHER THAN APPLICANT, PLEASE PROVIDE:

C.1 - CONTACT PERSON INFORMATION OF THE PERSON ASSISTING :

NAME (PLEASE PRINT)	RELATIONSHIP	TELEPHONE # ( )

X ______________________ SIGNATURE OF CONTACT PERSON	REASON WHY APPLICANT DID NOT COMPLETE THE FORM

END OF APPLICANT INFORMATION
Please continue to the next page to sign the Disclaimer

CANADIAN DISABILITY RESOURCES
4429 Kingsway #31
Burnaby, British Columbia, V5H 2A1
Phone and Fax 1-888-909-8974

Part D

DISCLAIMER

All applicants applying for funding in the categories outlined below are required to carefully read and complete this document. Your signature below is evidence that you understand and accept the content and terms of this document.

CONDITIONS OF FUNDING:
The applicant acknowledges that he/she is not relying on the approval for funding, or the approval of the C.D.R.S. of a particular therapist as any indication that such therapy will be effective or beneficial.

APPLICATION FOR FUNDING OF SERVICES AND EQUIPMENT:
C.D.R.S. , in approving funding, assumes no liability to the applicant for any damages arising directly, or indirectly, to the applicant as a result of any service or equipment for which funding approval is given.

In all categories, the applicant must make independent investigation of the treatment, services, equipment or counseling which is the subject of this application. The applicant must be in agreement with the choice of services to be provided.

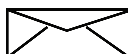
I also acknowledge that the C.D.R.S. has the right to use my photo as well as case history for public awareness campaigning in order to acquire funding for my project.

It is a condition of any funding, or continued funding, that this disclaimer be in effect for the categories outlined in this document.

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

END OF APPLICATION FORM



PLEASE SEND YOUR COMPLETED APPLICATION FORM TO:

CANADIAN DISABILITY RESOURCES
HEAD OFFICE
4429 Kingsway #31, Burnaby,
British Columbia V5H 2A1

The Statement of Intent on the next pages are to be filled out if your application is approved and you have received medical equipment from C.D.R.S.

CANADIAN DISABILITY RESOURCES
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Part E

STATEMENT OF INTENT:

PLEASE READ both pages of this form carefully and complete where applicable to you:

I, ___________________________________ acknowledge receipt of the following;

____

____

Model #________________________________ Serial #____________________________________(if applicable)

to which an I.D. Label has been attached identifying the contribution of the Canadian Disability Resources. (This Label is not to be removed.) The above, hereafter referred to as the "equipment", has been received from the Canadian Disability Resources, a non-profit organization.

I confirm that:

A) The Equipment was purchased entirely from funds supplied by the C.D.R.S. and no funds of my own were used in the purchase.

OR

B) The Equipment was purchased partially from funds supplied by the C.D.R.S. and partially from funds of:
❑ my own ❑ my family ❑ my friends ❑ other ______________
______________________________.

C) The Equipment will be used only by me for my personal use.

D) If I no longer need the Equipment, or in the event of my death, the equipment will be returned to the Canadian Disability Resources

(address) ____
____.
with the intent that it will be loaned to someone else who can benefit from its use.

E) I will not sell, transfer, lend or dispose of the equipment to anyone else.

F) I will ensure that my relatives, and anyone who may be responsible for me or my estate in the event of my death or incapacity is made aware of the above conditions It is my intent that my estate be bound by the above conditions.

G) I am aware that the C.D.R.S. is relying on the above in making the donation of the equipment to me.

ATTACH

PHOTO

HERE

____
Signature of Witness

____
Name of Witness (Print)

____
Address

____
Occupation

T0 WITNESS
MY INTENT

I have signed this statement on the

______ day

of ___________, 20__

____
Signature of Recipient/Legal care giver

____
Name of Recipient (Print)

____
Address

____
Phone #

CANADIAN DISABILITY RESOURCES
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Part E.1

STATEMENT OF INTENT on BEHALF OF RECIPIENT

PLEASE NOTE:

If an individual is signing this Statement of Intent for the Recipient, please complete this form.

RECIPIENT STATEMENT:

To WITNESS my intent, I ____________________________ have had this Statement signed on my behalf
(Name of Recipient)

on the _____ day of ________________, 20____

SIGNATORY TO FILL OUT:

I, ____ acknowledge that:
(Name of Signatory)

1. I attended in person with ______________________ on the ______ day of _________, 20____.
(Name of Recipient)

2. a) ___________________________ read the contents of this Statement of Intent, or;
(Name of Recipient)

b) I read the contents of the above document to ___________________________
(Name of Recipient)

3. He/She acknowledged to me that he/she understood, and agreed with the contents of this Statement of Intent, and instructed me to sign this Statement of Intent for him/her, as evidence of his/her agreement with the contents of this Statement of Intent; and his/her intention to be bound by it.

Witnessed by:	Signed on behalf of recipient by:
______________________	______________________
Signature of Witness	Signature of Recipient's Representative
______________________	______________________
Name of Witness (Print)	Name of Recipient's Representative (Print)
______________________	______________________
Address	Address
______________________	______________________
Occupation	Phone Number