Ministry of Community and Social Services

Ministry of Children and Youth Services

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Ontario

ASSISTANCE FOR CHILDREN WITH SEVERE DISABILITIES INFORMATION GUIDE AND EXPENSE REPORT

Applicant: _____ **Child's Name:** _____

Diagnosis: _____

The purpose of the ACSD program is to assist children with disabilities to live as normal a life as possible under parental care by providing a benefit to parents to help meet the **ongoing extraordinary** costs arising from the disability. Costs must be directly related to the child's qualifying diagnosis.

The ongoing extraordinary costs should represent the additional expenses related to the disability, as opposed to normal costs for any child in the same age group who does not have a disability. You may be required to verify these expenses. Please keep receipts.

MEDICAL TRANSPORTATION, LODGING, AND MEALS

Name of doctor / hospital	Location	# of yearly visits	How do you get there? (include return trip cost)		Parking cost per visit	Ministry Use Only
			# of kms (car)	actual cost (bus, train, taxi)		
TOTALS:	**# of kms total _____ x .18/km =**		**Total actual costs =**		**Total parking =**	

For out of town appointments:

Accommodation costs – Total accommodation costs if you are required to stay overnight for out of town treatment or medical care related to the child's disability. Describe your costs:

# of nights _____ x cost per night $_____ = $ _____/yr

Meal costs – Breakfast/lunch/dinner for child and parent for out of town treatments or medical care only.

Breakfast $5.00 x _____ persons x _____ # of trips = $_____/yr

Lunch $8.00 x _____ persons x _____ # of trips = $_____/yr

Dinner $15.00 x _____ persons x _____ # of trips = $_____/yr

Childcare costs – Cost of childcare for other children in your family, under 12, while attending an appointment or meeting related to your child's disability may be included. List and describe your costs:

# of appointments _____ x # of hours per appointment _____ x $_____/hr = $_____ /yr

MEDICAL EXPENSES		
Equipment for Hearing / Visual / Speech Impairments Expenses for hearing, visual, or speech impairments which are not covered by the Assistive Devices Program or private insurance. ➢ **Contact your supplier for further information on coverage for hearing aids, batteries, molds, and repairs, as these costs can be paid directly.** ➢ **For eye-glass coverage forward a copy of your child's eye-glass prescription to the address/fax number at the top of this form.** List and describe any other costs:	**Projected Yearly Costs**	**Ministry Use Only**
Drug Costs Cost of prescription medications *not* covered by an Ontario Drug Benefit Card, or other insurance plans. Non-prescription drugs supported and recommended by a physician directly related to your child's disability. **Note: The $2 dispensing fee on prescription drugs is not claimable.** List and describe your costs including how the medication is related to your child's diagnosis:		
Medical / Surgical Supplies Costs for medical or surgical supplies related to the disability, not including the portion covered by Assistive Devices Program (ADP) or private medical insurance plans. List and describe your costs:		
Dental Costs Costs not covered by the dental plan, which are directly related to the child's disability. Describe your costs:		
EDUCATIONAL EXPENSES		
Special Learning / Developmental Equipment If special items have been recommended by a professional for your child's learning and development, these items will be considered (i.e. books, specialized toys, etc). If the item is more than $25/month or $300/year, a copy of the recommendation and estimate for the item must be provided. You must list items and expenses to be considered:		
Specialized Day Care Day care costs can be claimed in situations where integration into a specific program has been recommended by a professional for stimulation and socialization. **Note: A professional's recommendation must be provided.**		
Special Education Costs for specialized programs that encourage socialization and physical stimulation. **Note: A professional's recommendation is required.** List programs and expenses:		

PERSONAL GROWTH & DEVELOPMENT EXPENSES		
Special Summer Camp Fees Cost of a specialized summer camp related to your child's disability. Name of Camp: _____ Actual Cost to Parent: $_____	**Projected Yearly Costs**	**Ministry Use Only**
Extraordinary Child Care and Babysitter Costs The difference between the cost of *specialized* child care/babysitting and regular child care/babysitting will be considered. If the child does not require specialized child care, no cost will be allowed. If your child is 13 years of age or older, child care will be approved at cost. Describe what these extraordinary costs enable you to accomplish (i.e. attending appointments, employment, grocery shopping): # of hours per month _____ x your cost $ _____/hr = $ _____		
Parental Relief To allow families relief or to allow parents more time to devote to other children in the family (up to a maximum of $150/month). Relief Worker name: _____ Phone: _____ # of hours per month _____ x $_____ /hr x 12 mths/yr = $_____		
One to One Worker / SSAH Cost Share Worker Name:_____ Phone:_____ # of hours per week _____ x $_____/hr x _____wks/yr = $_____ Special Services at Home / One to One Worker activity fees/travel expenses (up to maximum of $20 per month). $ _____/month x _____ mths/yr = $_____		
OTHER EXPENSES		
Please list any other costs not already listed that are incurred as a direct result of the disability. Please identify the items you are claiming and their separate costs: _____ $_____ _____ $_____ _____ $_____ _____ $_____		

Please provide any additional comments or information below.

_____

_____

_____

_____

_____

Signature of Parent/Guardian: _____ **Date:** _____

Please return to: Assistance for Children with Severe Disabilities "ACSD" address at top of first page.

PERSONAL CARE COSTS

	Projected Yearly Costs	Ministry Use Only
Clothing and Linen Costs Cost of specialized clothing/linen needed due to disability and/or additional clothing related to disability i.e. linen, underwear, pants. Expenses above $25/month require receipts. Explain and list your costs:		
Shoes / Boots ➢ Additional costs for shoes or snow boots directly associated with the child's disability. Three pairs of shoes and one pair of snow boots are considered basic. *If you are purchasing more than 3 pair of shoes you must describe how this relates to your child's disability. Describe: # of pairs of shoes purchased per yr ____ - 3 = ____ x $_____ = $ _____ # of pairs of boots purchased per yr ____ - 1 = ____ x $_____ = $ _____ ➢ Do you consider the cost of this footwear more expensive than regular footwear? Describe: # of pairs of shoes purchased per yr ____ x additional cost $_____ = $ _____ ➢ Does your child require orthotics? ☐ Yes How much of the cost is not covered by the Assistive Devices Program or private insurance? $ _____ **Note: Please include receipts.**		
Incontinence Supplies If a child over 3 continues to require diapers or incontinence briefs (i.e. pull-ups) parents should apply for Easter Seals funding, phone 1-888-278-7797. ACSD will include costs above Easter Seals funding + Incontinence Supply Grant Top-Up (Ages 3-5, $400 + $133.33 = $533.33; ages 6 and up $900 + $300 = $1200). *Note children with night-time enuresis only do not qualify for Easter Seals funding. # of packages per month _____ x $_____ = Your cost $ _____ Your Cost _____ minus Easter Seals Grant and Top Up _____ Allowable Expense _____		
Special Diet A special diet request must be supported through a recommendation by a medical professional. Special Diet Application forms can be obtained by contacting the ACSD office. **Note: Families in receipt of ODSP or OW should contact these programs for special diet costs.** Specify the special diet required:		
Laundry Costs Additional laundry costs directly associated to the qualifying child (i.e. bedwetting, drooling). Four loads of laundry per week are considered basic. Describe your costs: # of loads (in excess of 4) per week_____ x $3.00 x 52 weeks = $ _____		