Ministry of Community and Social Services
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Ontario

Assistance for Children with Severe Disabilities (ACSD) Diagnostic Form

The Assistance for Children with Severe Disabilities is a benefit provided to parents caring for children with disabilities resulting in a severe functional loss. In order to determine eligibility, medical documentation from a licensed physician or a registered psychologist is required. This form is provided for your use when an alternate assessment (ie. psychological, audiological) report is not available. Please have a Licensed Physician or Registered Psychologist complete the entire form. You may also include any additional information (i.e. hospital reports, consultant reports, and other tests) that may help clarify the child's physical or mental impairment.

Applicant's Name:	
Child's Name:	**Date of Birth:**
Address:	**Telephone Number(s):**

Please have Physician/Psychologist complete the diagnosis, checklist, and sign below.

Diagnosis: _____

"Severely Disabled Resulting in Functional Loss" refers to an ongoing mental or physical condition which results in a major loss of ability or capacity to engage in any substantive activity commonly necessary and appropriate to normal daily living. This definition is not intended to specifically include or preclude any particular type of disability. It is intended to clarify that a disability must constrain normal daily living and to provide a standard by which the severity of that disability may be judged.

Based upon the above definition and in your professional opinion does this child meet the criteria as severely disabled? Yes ____ No _____

- ☐ Medically Fragile
- ☐ Visual Deficit (mild, moderate, severe)
- ☐ Intellectual Delay (mild, moderate, severe, profound)
- ☐ Speech Delay (mild, moderate, severe)
- ☐ Non-ambulatory/confined to a wheelchair
- ☐ Incontinent
- ☐ Special Diet _____
- ☐ Needs assistance to feed oneself
- ☐ Needs assistance with self-care
- ☐ Needs assistance with transfers
- ☐ Hearing Deficit (mild, moderate, severe)
- ☐ Learning Disability (mild, moderate, severe)
- ☐ Uses augmentative communication
- ☐ Uses prosthesis or other walking aids
- ☐ Night-Time Enuresis
- ☐ G-tube or NG tube fed
- ☐ Needs assistance with dressing
- ☐ Exhibits maladaptive behaviour
- ☐ Concerns with respect to impulse control and attention span
- ☐ Does not recognize common dangers in the home or community
- ☐ Unable to participate physically in sustained activity
- ☐ Medication: _____
- ☐ Receives treatment/therapy: _____

Does this disability limit the child's daily activities? Yes ____ No _____

If yes, please describe. *Please print.* (Please include attachment if necessary.)

_____

_____

_____

_____

Signature of Physician/Psychologist _____

Name of Physician/Psychologist (Please Print) _____

Address _____

_____

_____

Phone Number _____

Date _____