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MSIFN Donations Committee

Application for Assistance – Medical

Form for Occupational Therapists, Social/Case workers, support personnel, etc.

Applicant Information (Person to receive funding)

Name: _____ Status Aboriginal Person? Y ☐ N ☐

Date of Birth: _____ If yes, where? _____

Address: _____ Township/Region: _____

_____

Medical Condition: _____

_____

_____

Requestor's Information

Name: _____

Position/Title: _____ Organization: _____

Contact Address: _____

Phone and Email : _____

Checklist of Requirements - Please submit with your request

- ❑ Letter of Recommendation
- ❑ 2nd Letter of Recommendation (Appreciated when possible)

From an authorized Occupational Therapist, Physician, Physiotherapist, Social/Case Worker, Family Support personnel, etc.

Equipment or Construction Quotations - Please provide from 2 sources

- ❑ Company A _____
- ❑ Company B _____

**Note all requests for building ramps, decks, etc. for clients with disabilities must adhere to the standards of the Ontario Building Codes, and be compliant with the AODA.*

Proof of Income

- ❑ Applicant
- ❑ Parents of Minors
- ❑ Spouse or Common Law Partner of Applicant
- ❑ Other

Please provide a Notice of Assessment or 2-3 Recent Paystubs of everyone in the household of 18 years old and older.

Other Funding Support Accessed

MSIFN Donations Committee wishes to be the last resort for funding. Please provide evidence of all efforts made to access alternative funding by checking (✓) the organization and stating the result in the table below.

ORGANIZATION	✓	RESULT ($)
March of Dimes	❑	
Easter Seals	❑	
President's Choice Children's Charity	❑	
Assistance for Children with Severe Disabilities (ACSD)	❑	
Love of a Child	❑	
Assistive Devices Program (ADP)	❑	
Home & Vehicle Modifications	❑	
MS Society	❑	
Muscular Dystrophy Association	❑	
Ontario Federation of Cerebral Palsy	❑	
Kawartha Participation Projects (KPP)	❑	
Ontario Works Discretionary Fund	❑	
Durham Region – Social Assistance/Oral Health Division	❑	
Durham Partners in Service	❑	
Private Insurance	❑	
Employer Extended Health Benefits	❑	
Go Fund Me	❑	
Local Rotary Club	❑	
Other - *(please specify)*	❑	
Other -	❑	
	❑	

I hereby provide my consent for MSIFN Donations committee to seek specific details regarding other funding.

Applicant's Signature _____

Application Submission

Please forward completed requests by:

Fax to 905-985-8828 Attn: MSIFN Donations Committee or
Email to Donations@ScugogFirstNation.com

Thank you for your cooperation with our process for requests. All applications will be reviewed by the MSIFN Donations Committee at the meeting following receipt of all requirements of your request. Approved requests will be paid directly to the service or equipment provider when applicable. Due to the high volume of requests received, only one request per year will be considered. All personal information received with an application will be kept confidential, only viewed by MSIFN Donations Committee members.

With kind regards,

Kayla Ponce de Leon

MSIFN Donations Committee Administrative Assistant

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