Ontario Federation for Cerebral Palsy

LEAF

LEAF Application Form 2018 - 2019

Date: ______________________
Year / Month / Day

Individual Membership ID#: ____________
(Applicant)

Complete this application form in full.
Attach all required documentation.
Incomplete applications will be returned.
Print in pen, submit to OFCP by postal mail, fax (416-244-6543) or email (leaf@ofcp.ca)

** Please keep attached LEAF Program Guidelines for your reference when accessing funds.*

Applicant's Information

Name (who the activity is for): ______________________________
First Name Last Name

Date of Birth: ______________________ Diagnosis: Cerebral Palsy
Year / Month / Day

Address: ______________________________

New Address - Please update my information ☐

City: ______________________ Postal Code: ____________

Home phone: ______________________ Bus. Phone: ______________________

Email: ______________________________ ☐ I would like to receive OFCP comunications

Primary Contact (if applicable)

Name of Primary Contact: ______________________________
(parent or guardian required if the applicant is under 18 years) First Name Last Name

Relationship to applicant: ______________________________

Address: ______________________________

New Address - Please update my information ☐

City: ______________________ Postal Code: ____________

Home phone: ______________________ Bus. Phone: ______________________

Email: ______________________________ ☐ I would like to receive OFCP comunications

Life Enriching Activity

I am applying for: ______________________________

Duration of Activity From: ______________________ To ______________________
Year / Month / Day Year / Month / Day

Activity Provider: ______________________________

In what way(s) would this activity enrich your life? ______________________________

____

Do we have permission to use your story in our promotional material (facebook, newsletter, etc...) Yes__ No__

Funding Summary

LEAF Funding Request Summary

Note: OFCP will consider one LEAF request up to a maximum of $500 per member per funding year.

	Item	Amount ($)	Office Use Only
Line 1	Estimated total cost for activity (activity provider quote required)		
Line 2	Total funds requested from the OFCP		

Please Make Cheque Payable to:

Check one of the following:

☐ Applicant / parent / guardian	☐ Activity provider
Name: ____________________	Name of provider: ____________________
Address: ____________________	Address: ____________________
____________________	____________________
Relationship with applicant: __________	Phone number: ____________________

Please Note: If we are to pay provider directly, a cheque will be mailed once activity is complete and attendance is confirmed

Checklist (please complete before submitting your application)

You must be able to answer YES to all of the questions below prior to application

	Yes	No
Have you read **ALL** of the guidelines and eligiblity criteria including **who can apply**?		
Have you included a price quote/estimate? (required from the activity provider)		
Have you included information about the activity? (required from the activity provider)		

Have you included;

1) an invoice from the activity provider?

OR

2) paid receipt for the activity? (not required for initial application, but is required upon approval after activity completed)

When was the last time you received funding in either the LEAF or Activity Funding Program? ____________

Financial Need (Check off your household yearly income)

Under $20,000	
Between $25,000 and $45,000	
Between $45,000 and $70,000	
Between $70,000 and $95,000	
Over $95,000	

Please explain your financial circumstances to help us understand why you are applying for LEAF:

____

____

Physical Support Services Form

This form is only used if your application is for Physical Support Services.

Please print.

Activity attended: ____

Applicant's name: ____

Attendant's name: ____

Dates of activity: ____

Hours of Physical Support Services provided (up to $15 per hour): ____________________

I ______________________________ **confirm that the above mentioned attendant is not**
applicant's name

a family relative, and carried out the Physical Support Services as stated.

Attendant's signature: ____

Applicant's signature: ____

Signed on date: ______________________

Sample Receipt required information

Name of Service Provider:

Address:

Telephone number:

Name: (Client/Applicant/Parent)

Receipt or Receipt #	
Date:	
Issued to:	
Address:	
Description of activity	
Dates of activity	Amount Paid:

____
Signature of Service Provider

____
Signature of Applicant/Parent/Guardian

Indemnity

I hereby indemnify and save harmless the Ontario Federation for Cerebral Palsy, its officers, directors, employees and agents from and against any and all claims, demands, liabilities, losses, costs, expenses, damages, actions, suits and other proceedings arising out of the activity described in this application. I understand that the Ontario Federation for Cerebral Palsy acts as a third party funder and as such has no role in choosing, recommending or selecting an activity, product or equipment and that any payment from OFCP LEAF program is not an acknowledgement that the activity is acceptable for the purposes intended.

Privacy

The OFCP collects, uses and discloses personal information related to this application only for the purposes of assessing, processing and administering this application and may exchange such information with the above-mentioned contact person, vendors, medical professionals and other agencies. I consent and (as applicable) confirm the user's consent to this collection, use, disclosure and exchange of personal information. For additional information regarding the OFCP's personal information protection privacy practices, please refer to our Privacy Policy on the OFCP website.

Certification

I certify that the information provided in this application is true, correct and complete to the best of my knowledge.

By providing your signature below, as the applicant or applicants guardian, you are giving permission to OFCP staff to process your application accordingly.

☐ I confirm that I have read and understand all of the OFCP LEAF Program criteria & guidelines

Signature: ______________________________ Date: ______________________________

Relationship to Applicant (if applicable): ____

Please ensure all information and supporting documentation are provided. If any information is missing, the application will be returned to you for completion, resulting in a delay in processing the request. A copy of the completed form should be kept for your files.

If you have any questions please contact:

Ontario Federation for Cerebral Palsy
416-244-9686 ext: 221
or toll free 1-877-244-9686 ext: 221
Email: leaf@ofcp.ca
Website: www.ofcp.ca

Return the completed form by email (leaf@ofcp.ca), fax (416-244-6543), or mail to:

Ontario Federation for Cerebral Palsy
LEAF Program
1630 Lawrence Avenue West, Suite 104
Toronto, Ontario
M6L 1C5