65, rue Brunswick Street, Fredericton, N.-B., E3B 1G5

Tel: 506-458-8739
Fax: 506-457-2863
E-mail: info@easterseals.nb.ca
Web: www.easterseals.nb.ca

APPLICATION TO PERSONAL SERVICES PROGRAM

Easter Seals New Brunswick (ESNB) is a charitable, non-profit organization, which provides services to children and adults with a disability. ESNB provides the long-term loan of rehabilitation mobility equipment recommended by a therapist. The PSP Program is set up to provide services to individuals in the province of New Brunswick who have: no ability to rent or purchase, no medical coverage or health card, no other agency is able to provide the services.

ESNB may offer financial assistance for travel and accommodation expenses to enable ESNB clients to attend medical appointments. ESNB may also assist in the financing of items such as; orthopedic footwear, computers or technical aids.

The majority of ESNB funding comes from private donors and service clubs. It is ESNB's responsibility to distribute their gifts as wisely as possible. In order to do that, ESNB must ask that you fill in the proper paperwork for the services you are requesting. ESNB will do their best to provide you services.

SECTION I - Identifies the applicant- Would need to accompany all requests + Sections that cover the services you require
SECTION II - Professional's Recommendation
SECTION III - Travel OR Ortho needs-Please provide all receipts for reimbursement
SECTION IV - Wheelchair Spec Form-If a wheelchair is being requested

Application needs to be sent to:

Easter Seals New Brunswick
Personal Services Program
65 Brunswick Street
Fredericton, NB
E3B 1G5
1-888-280-8155
FAX #: 1-506-457-2863

Please ensure you retain a copy of the application for your records along with this information sheet

Easter Seals Timbres de Pâques
New Brunswick Nouveau Brunswick

65, rue Brunswick Street, Fredericton, N.-B., E3B 1G5

Tel: 506-458-8739
Fax: 506-457-2863
E-mail: info@easterseals.nb.ca
Web: www.easterseals.nb.ca

SECTION I - Applicant's Information

Applicants Name:_____ Medicare #:_____

Address:_____ City: _____

Postal Code: _____Telephone: _____Date of Birth:_____
DAY MONTH YEAR

My disability affects my functioning in the following areas:

Communication____	Self-care ____	Hearing ____
Mobility ____	Feeding ____	Life-sustaining therapy ____
Transfers ____	Vision ____	Loss of limb ____
Other ____		

Next of Kin/Relationship:_____ Telephone # :_____

If the applicant is a child is she/he registered as a *Special Needs* child with the Department of Social Development?
Yes _____ No _____

Does the applicant have a Health Card? Yes_____No _____

Does the applicant / family have any health or medical insurance? Yes_____No _____
If yes, Company: _____

Is the applicant registered with an organization which serves persons with his/her disability ***(e.g. Cancer Society, ALS, Muscular Dystrophy Association, Heart Foundation, MS Society)*** Yes_____No _____
If yes, which organization: _____

Has the applicant received assistance from any other agency regarding this request? Yes_____No _____
If yes, please give details:_____

ESNB does not charge a fee for service. However the costs of refurbishing and shipping equipment can be substantial and ESNB relies heavily on donations. If you are able to make a donation, to help ESNB deliver these important services, a tax receipt can be provided for all donations of $ 20.00 or more.

I, _____, the applicant, give my permission to share my personal information with another agency only as it pertains to processing my application.

Applicant's signature: _____ **Date:** _____

THIS SECTION MUST ACCOMPANY ALL REQUESTS

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SECTION ll - Professional's Recommendation

Client Name: _____ **Medicare #:** _____

MOBILITY EQUIPMENT: *(include size and/or measurements or equipment description, if* ***a wheelchair is being requested, ESNB w/c Rx Specs form must accompany this application before application can be processed****)*

1) _____

2) _____

3) _____

4) _____

EQUIPMENT TO BE SHIPPED TO WHAT GEOGRAPHIC ADDRESS :

ATTENTION TO WHOM, _____

Street Address : _____ City: _____

Postal Code: _____ Tel: _____

(ESNB NEEDS A GEOGRAPHICAL ADDRESS, A P.O. BOX IS NOT APPROPRIATE FOR SHIPPING EQUIPMENT)

Health Care Professional: _____ _____

Please Print Your Name & include Your Profession **E-MAIL FOR ESNB TO CORRESPOND**

_____ _____ _____ _____

Street **City** **Postal Code** **Telephone Number**

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SECTION lll – FINANCIAL, TRAVEL, ORTHOTIC AND OTHER REQUESTS

Applicants Name: _____ Medicare #: _____

1) TRAVEL:

Reason for travel: _____

Health Care Professional Name: _____

Date of travel: Date Travel to: _____ Date Travel From: _____

The type of expense you would need assistance with:

- ○ TRAVEL
- ○ MEALS
- ○ LODGING
- ○ OTHER

Please save all your receipts for submission to ESNB for any reimbursement you are requesting

2) ORTHOTIC, PROSTHETIC, ORTHOPEDIC SHOES / FOOTWEAR LIFTS:

All applications should be accompanied by a quote from a qualified supplier.

Prescribed by: _____

Supplier's name and contact person: _____

Address: _____ Tel #: _____

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SECTION IV – WHEELCHAIR SPECIFICATIONS / SPÉCIFICATIONS DE FAUTEUIL ROULANT

Client Name / Nom du client:	Medicare # D'assurance-maladie
	ID # (healthcard)/Identification:

Chair size/Taille de la chaise:	Seat width/Largeur du siège:
	Seat depth/Profondeur du siège:
	Seat to floor height / Hauteur siège-sol: WITH cushion / avec coussin □ WITHOUT cushion / sans coussin □
	Leg length/Longueur de la jambe:
Back / Dos:	Style / Modèle:
	Height / Taille:
Arms / Bras:	Style / Modèle:
	Height / Taille:
Frame style/Modèle de la Charpente:	
Drive / Commande:	
Front rigging/Repose-pied:	
Wheels / Roues:	Castors/Roulettes:
	Rear / Arrière:
Wheel locks / Blocages de roues:	Tires / Pneus:
	Handrims / Jante à main:
Cushion / Coussin:	Type of cushion :
Accessories / Accessoires:	

OTHER INFORMATION / AUTRES INFORMATIONS

Therapist Name and E-Mail / Therapeute Nom & Courier Elèctronique:	
Telephone / Téléphone:	Date:

Registered as the Canadian Rehabilitation Council for the Disabled, NB Branch Inc.
65 Brunswick Street, Fredericton, NB E3B 1G5
Phone: (TDD Voice) 506-458-8739 Fax: 506-457-2863
E-mail: info@easterseals.nb.ca
Website: www.easterseals.nb.ca

Enregistré sous le nom de Conseil canadien pour la réadaptation des handicapées, division du N-B Inc.
65, rue Brunswick, Fredericton, (N.-B.) E3B 1G5
Tél: (Téléscripteur) 506-458-8739 Télécopieur: 06-457-2863
Courrier électronique: info@easterseals.nb.ca
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