



DAY PROGRAM FUNDING ASSISTANCE APPLICATION FORM

Date of Request: _____
Year / Month / Day

Please print in pen, faxed copies will not be accepted

Please Note: Day Program Funding Assistance is only available to Individual Members of the Ontario Federation for Cerebral Palsy

Please review the guidelines carefully before submitting your application

FOR OFFICE USE ONLY

Date Received _____

File Number _____

OFCP Contact _____

Date Approved _____

Cheque Issued _____
Year / Month / Day

Amount \$ _____

Individual Membership Number _____

APPLICANT INFORMATION

Name (who the day program is for): _____
First Name Last Name

Date of Birth: _____ Diagnosis: _____
Year / Month / Day *Cerebral palsy support documentation required*

Address: _____

City: _____ Postal Code: _____

Telephone (home): _____ Business: _____

Email: _____

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: _____

City: _____ Postal Code: _____

Telephone (home): _____ Business: _____

Email: _____

DAY PROGRAM PROVIDER

Name of Provider: _____

Address: _____
Street City Postal Code

Activity: _____

Duration of Day Program: From: _____ To: _____
Year / Month / Day Year / Month / Day

Benefits of Day Program to Applicant: _____

FUNDING SUMMARY

DAY PROGRAM FUNDING REQUEST SUMMARY

	Item	Amount (\$)	Office Use Only
Line 1	Estimates total cost of activity		
Line 2	Funding from other sources		
Line 3	SUB TOTAL <i>(LINE 1 SUBTRACT LINE 2)</i>		
Line 4	TOTAL COST REQUESTED FROM OFCP <i>(SAME AS LINE 3 UP TO \$1500)</i>		

Please Make Cheque Payable to: _____

Funds will not be released until the OFCP receives invoices or paid receipts. Please review the guidelines for details.

Special Comments: _____

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 day program 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 a day program and that any payment from the OFCP Day Program Assistance is not an acknowledgement that the day program 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 applicant guardian, you are giving permission to OFCP staff to process your application accordingly.

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 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 the Ontario Federation for Cerebral Palsy:

416-244-9686 ext: 223
or toll free 1-877-244-9686 ext: 223
Email: vacp@ofcp.ca
Website: www.ofcp.ca

Return the completed form by mail to:

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