Special Needs PROGRAM

Special Needs Fund Application

Applicant: This section conforms to the MCA *Access to Information of Personal Privacy Regulation, Chapter Three, Section 37* which states, “A department must collect personal information directly from the individual to whom the information pertains unless another method of collection is authorized by the individual” and with Section 41 a) which states, “A department may use personal information only for the purpose for which the information as collected or compiled or for a use consistent with that purpose”.

SECTION A: Applicant Identity

FOR OFFICE USE ONLY:

FILE NUMBER: ____________________

This application is for:

☐ myself

☐ another person for whom I am authorized to divulge personal information

Applicant: ____

On behalf of: ____

Birth date: ______________________________ MM/DD/YYYY

I am, or I am applying on behalf of, an MCA Member as defined by the Akwesasne Membership Code; I understand that this will be verified by the MCA Office of Vital Statistics and provide information, attached, for verification.

Physical Address: ____

Mailing Address: ____

District : ☐ Kawehnoke ☐ Kanatakon ☐ Tsi Snaihne

Contact information: ____

Phone Number: ____

Email: ____

CONTACT PREFERENCE: ☐ Mail ☐ Email ☐ Phone ☐ All

If applicable:
School District Attending: ____
School Contact: ____

Note to Applicant: All applications are contingent to available funding. In all cases, you are encouraged to use additional paper when pertinent information requires additional space.

Committee members seek to fully understand your special need.

Contact Information

Phone | (613) 575-2341 ext. 3308
Email | Specialneeds@akwesasne.ca
In-person | Kanonhkwatsheriio Health Facility, 31 Hilltop Drive, Akwesasne QC H0M 1A0

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SECTION B: ASSESSMENT SUMMARY

Please identify the professional(s) with whom you've consulted, and attached pertinent documentation. Please type or print clearly.

Professional: ____

Dates: ____

Assessment: ____

Diagnosis/Recommendation:

____

____

____

____

Professional: ____

Dates: ____

Assessment: ____

Diagnosis/Recommendation:

____

____

____

Summary of current special needs for the individual and/or family:

____

____

____

Summary of circumstances that warrant special consideration pertinent to this request:

____

____

____

____

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SECTION C: REQUEST FOR FUNDING

- ☐ Equipment
- ☐ Education Support
- ☐ Home Repair
- ☐ Vehicle Adaptation
- ☐ Respite Care
- ☐ Therapy
- ☐ Assessment Fees
- ☐ Other (please specify)____

____

Please describe in detail the request being made and how it will support the special needs of the applicant:

____
____
____
____

Total Estimated Cost(s): $ ____

If the request is over $3,000.00, Please attached a minimum of three quotes for the above noted request.

SECTION D: Additional Details

Please list alternate sources of funding that are, or may be available to you:

____
____
____
____

Applicant must attach copies of ALL denial letters and or documentation received regarding previous attempts to secure funding or services.

If applicable:
I am the Parent or Guardian of a minor, ___________________________________. I declare and certify that this minor is resident in my home on a full-time basis. Where another living situation exists, I have correctly described it on the bottom of this page.

Signature: ____ Date: _______________________

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Mohawks of Akwesasne
Membership Confirmation Request

Please complete your name and date of birth. Submit to OVS Office for verification of membership status.

Part I:

Name: ____

Date of Birth: ____

Registry Number: _______________________________________

____
Signature of Applicant or Authorized Representative

I have applied to the Special Needs committee for funding. The Committee will need additional membership information as listed in part II before assistance can be determined. When complete, please forward to DCSS Administration office.

FOR OFFICE USE ONLY:

Part II: STATUS OF MEMBERSHIP

☐ Member under Akwesasne Membership Code

☐ Probationary member under the Akwesasne Membership Code

Expiration Date of Probation ______________________________

☐ Not a member under Akwesasne Membership Code

______________________________ ______________________
OVS Authorized Signature Date

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Special Needs Policy Expense Allotments
Annual Maximum Costs

Pending Fund Availability

Costs	Annual Maximum Allowable
	Assistive Devices
Equipment/Repair	100% to a maximum of $15,000
	Services
Therapeutic Education (OT, PT)	100% to a maximum of $5,000
Assessment	100% to a maximum of $5,000
Respite Care	100% of costs up to a maximum of $20,000
Training for Caregivers	90% of Registration Cost up to a maximum of $1,000
Support in the home	Not covered
Drug & Alcohol Rehabilitation	Not covered
	Supports
Travel (hotel, mileage)	Reimbursement of original receipts
Meals	Not covered
Medications	Not covered
Special Diet	Not covered
	Special Circumstances
* Home Adaptation	75% of costs up to a maximum of $25,000
* Vehicle Adaptation	75% of costs up to a maximum of $10,000

*refer to Special Needs Policy on what is specifically covered.

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Consent Regarding Use of Personal Information

I, ____________________________________, certify that this application contains correct, complete information and hereby give my consent to the Special Needs Committee to discuss, confirm, or research any matter pertaining to, and consistent with, this application. I understand that this may include, by not be limited to, the professionals, schools, service providers, or funding agencies listed on the application. I understand that the Special Needs Committee is bound by the *Access to Information and Protection of Personal Privacy Regulation* in the collection, use storage, and disposition of this personal information.

The purpose of this form is to obtain formal consent for the Special Needs Committee to work collaboratively with other departments and programs within the organization to provide support and services to individuals with special needs.

Scope of Collaboration:
By signing this form, the consenting department/program agrees to:

- Cooperate with the Special Needs Committee in developing and implementing inclusive strategies and accommodations.
- Share relevant information to enhance service coordination and effectiveness.
- Provide the efficient and effective services.

Confidentiality:
All parties involved agree to maintain strict confidentiality regarding any personal or sensitive information shared during collaborative efforts, in accordance with the organization's confidentiality and privacy policies.

Duration:
This agreement is effective upon the date of signature and will remain in effect unless formally withdrawn in writing by either party.

Consent Statement:
I hereby acknowledge and consent to the collaboration between the Special Needs Committee and my department/program. I understand the purpose, scope, and responsibilities involved and agree to support the collaborative efforts in a professional and respectful manner.

☐ Yes, I give consent to the Special Needs Committee

☐ No, I do not give consent to the Special Needs Committee

Applicant Name (Print): ____

Signature: ____

Date: __________________________

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Special Needs Application Checklist

Required Documents (for all applications)

- ☐ Completed and signed **Special Needs Program Application Form**
- ☐ Proof of Residency within Akwesasne (Utility, Hydro bill/Lease)
- ☐ Copy of Applicant's Status Card
- ☐ Homeowner proof (If requesting Home Adaptation)
- ☐ Denial letters from all alternate sources

Supporting Documentation (depending on request type)

Medical/Professional Needs

- ☐ Medical or Professional Assessment(s) confirming the special need
- ☐ Prescription or recommendation from health professional (if applicable)

Equipment/Services

- ☐ Minimum of THREE (3) quotes or estimates from suppliers or service providers

Home Modifications

- ☐ Occupational Therapist or professional recommendation for modifications
- ☐ Contractor's estimates (minimum of THREE (3) quotes)

Respite or Support Services

- ☐ Service provider's letter, contract, or program details
- ☐ Cost breakdown of services requested

Financial Information

- ☐ List of other funding sources applied to (denial letters where applicable)

Applicant Declaration

- ☐ I have attached all required documents to this application.

Applicant/Parent/Guardian Signature: ____

Date: ____________________

Please note missing information may result in an incomplete application.

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