



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

This application is for:

- myself
- another person for whom I am authorized to divulge personal information

FOR OFFICE USE ONLY:

FILE NUMBER: _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Equipment | <input type="checkbox"/> Vehicle Adaptation | <input type="checkbox"/> Assessment Fees |
| <input type="checkbox"/> Education Support | <input type="checkbox"/> Respite Care | <input type="checkbox"/> Other (please |
| <input type="checkbox"/> Home Repair | <input type="checkbox"/> Therapy | 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 |
|--------------------------------|---|
| <u>Assistive Devices</u> | |
| Equipment/Repair | 100% to a maximum of \$15,000 |
| <u>Services</u> | |
| 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 |
| <u>Supports</u> | |
| Travel (hotel, mileage) | Reimbursement of original receipts |
| Meals | Not covered |
| Medications | Not covered |
| Special Diet | Not covered |
| <u>Special Circumstances</u> | |
| * 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, but 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 PROGRAM

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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