***** For internal use ofBuds in Bloom only *****

FINANCIAL HEALTH – BOURSARY REQUEST

Child's Name: _____Date of Birth: _____
YYYY-MM-DD

Basic Medical Information
Diagnosis(es) *join additional document detailing diagnosis(es)*): _____

Health Insurance Number: _____ Expiration Date:_____

Social Insurance Number* (if applicable): _____ Expiration Date: _____

* *This information allows us to better evaluate the eligibility of your family for our services, as well as the financial needs of your family.*

☐ **Check here is you provided a copy of all medical, educational and school reports within the last 12 months.**

Name of the Parents:_____ _____
Mother **Father**

Contact Information of the Mother (guardian)	**Contact Information of the Father (guardian)**
Adress: _____ N° Street City Province Code postal Tel.: Home: _____ Office:_____ Cell.: _____ Email Adress: _____	Adress : _____ N° Street City Province Code postal Tel.: Home: _____ Office:_____ Cell.: _____ Email Adress: _____

c/o Abby Kleinberg-Bassel for Buds in Bloom
5250 Ferrier Street Suite 801 Montreal, Quebec H4P IL4 | Info@BudsinBloom.org | www.BudsinBloom.org

GOVERNMENT SUBSIDY

(e.g. CLSC, supplement for handicapped child, etc.)

☐ No

☐ Yes _____
Name or title of the subsidy

Specify for what service(s) the subsidy is granted.

SERVICE	AMOUNT GRANTED($)	AMOUNT ALREADY USED ($)	END DATE OF THE SUBSIDY (if known)
ABA, therapy for ASD or PDD			
Occupational therapy			
Speech-language pathology			
Physiotherapy			
Psycho-education			
Psychology			
Other (e.g., special education, respite, material, etc.)			

OTHER SUBSIDY:

(e.g.President Choice Foundation for children, Noël au printemps Foundation,etc.)

☐ No

☐ Yes _____
Name or title of the subsidy

Specify for what service(s) the subsidy is granted.

SERVICE	AMOUNT GRANTED ($)	AMOUNT ALREADY USED ($)	END DATE OF THE SUBSIDY (if known)
ABA, therapy for ASD or PDD			
Occupationaltherapy			
Speech-languagepathology			
Physiotherapy			
Psycho-education			
Psychology			
Other (e.g., special education, respite, material, etc.)			

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PRIVATE MEDICAL OR HEALTH INSURANCE

☐ No

☐ Yes _____
Name of the insurance company

Specify what service(s) the insurance company covers.

SERVICE	LIMITE par JOUR ($)	LIMITE par VISITE ($)	LIMITE par AN ($)
ABA, therapy for ASD or PDD			
Occupational therapy			
Speech-language pathology			
Physiotherapy			
Psycho-education			
Psychology			
Other (e.g. special education, respite, material, etc.)			

N.B.: Indicate non applicable (**NA**) if there is no coverage. Note that **all boxes must be filled** before your request is treated.

Names of insured parent(s): _____

Insurance policy number: _____

Name of the group (if applicable): _____

Other relevant insurance information: _____

OTHER SOURCES OF FINANCING

☐ No

☐ Yes _____
Name of other financial sources

COMBINED FAMILY SALARY

In the last income tax year, what was the declared combined salary** of your family? $ _____._____

**: Combined salary means the added income gained by any and all person(s) living in the child's household.

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ADDITIONAL COMMENTS OR JUSTIFICATIONS

What are the main reasons that your child and family should receive a boursary or financial support? For instance, say for how long you have been waiting for therapy or intervention from the public sector, or how long will you need to wait. Add an extra sheet if more space is needed.

_____

_____

_____

_____

Specifically, without the help of our organization, indicate the **wait time**, in months, that your child **will face** for each of the following services (indicate **NA** for any service you are **not waiting for**):

☐ ABA, traitement TSA ou TED _____

☐ Ergothérapie _____

☐ Orthophonie _____

☐ Physiothérapie _____

☐ Psychoéducation _____

☐ Psychologie _____

☐ Orthopédagogie _____

☐ Autre(nommez-le) _____

NB: Note that **all lines must be completed** before your request is treated.

Two optionsare offered to you (check ONLY ONE box):

☐ 1 –Request to open a file for only $ 49;

☐ 2 –Request to open a file and become a member (including the right to vote at the annual general assembly, the privilege to view the financial statementand to receive news before the general public). An additional annual membership fee of $ 1 $ is requested, totalling $ 50.

Note that the request to open a file includes **free access to a specialized service**. For all requests to access more than one service, supplemental fees of $ 29 may be assessed. You can add a request for access to a service at all times.

Please move to the final signature page.

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As the parent or guardian of _____,
(***child's name in printed letters***)
I request that the non-profit organization Buds in Bloom offer my child **access to a specialized service**. I therefore accept to pay the previously detailed fees, either a total of **$ 49 or $ 50**, according to the selected option.

I understand that my request to open a file includes **free access to one specialized service**, and that I will have to disburse a $ 29 fee per supplemental specialized service. So, if I request access to two specialized services, such as occupational therapy and speech-language pathology, I accept to pay $ 29 more.

_____ _____

Name in printed letters of the **mother (guardian)** Date

_____ _____

Name in printed letters of the **father (guardian)** Date

N.B.: The written authorization and signature of both parents, or guardians, are strongly encouraged to process your request.

Please return the original questionnaire completed **(copies are not accepted)**, accompanied by the items listed in the "New Family Questionnaire" to:

c/o Abby Kleinberg-Bassel for Buds in Bloom
5250 Ferrier Street, Suite 801
Montreal (Quebec) H4P 1L4

Thank you.

Creating a **Canada** where every family living with special needs gets help today, since 2011.

For the best family start ©

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