DURHAM SPECIAL NEEDS ALLOCATION PROGRAM
FOR ADULTS WITH A DEVELOPMENTAL DISABILITY
CRITERIA FOR FUNDING

PURPOSE

The funds provide assistance to adults with developmental disabilities and their families. They focus on extraordinary situations that require critical supports during a crisis/transitional situation that are short-term in nature and existing services are not able to respond expediently to the situation.

PRINCIPLES

- To focus on people/families who have exhausted the capacities of the existing service system and who are facing extraordinary situations where short-term support is needed to bridge a more stable situation or plan.
- To improve access to funds by individuals and families and ensure an equitable distribution
- To encourage community partnerships that provides more effective use of existing resources.

ELIGIBILITY CRITERIA

- Adults with developmental disabilities
- Primary residence is within Durham Region and individuals would be accessing services within Durham.
- Must be in crisis (significant safety issues, requires additional supports to be maintained) or in transition (plan identifies option for on-going support)

LIMITATIONS

- A cap of $7500 within a 12 month period will be in place for individuals
- Hourly rates will be determined based on the lesser of the requested figure or the DSNAP scales for specific qualifications.
- Very limited funds are available and therefore it may be beyond the capacity of the committee to fund all eligible requests. It will be necessary to prioritize applications based on greatest need.
- Proposals must be received by the submission date to be considered for that month. If there is insufficient time to review all the applications, they will be brought forward to the next regular monthly meeting date of the DSNAP committee.

APPLICATION FORM

PLEASE TYPE OR PRINT*

OFFICE USE ONLY:
Date Rec'd: _____
Initials: _____
 # Assigned: _____
Amount Requested: $_____

SECTION I

APPLICANT'S NAME: _____ GENDER: M___ F___

D.O.B.: _____ AGE: _____
(mm/dd/yy)

PARENT/GUARDIAN(S) NAME(S): _____

ADDRESS: _____

CITY: _____ POSTAL CODE _____

PHONE #: H) _____ B) _____IF

APPROVED FOR FUNDING, CHEQUE SHOULD BE ISSUED TO:

_____

REASON FOR REQUEST: CRISIS [ ] TRANSITIONAL [ ]

I/we verify that all information contained in this application is true and correct and complete to the best of my/our knowledge. I understand that incomplete applications will be returned.

Signature: _____ Date: _____
(Applicant/Parent/Guardian)

ASSISTING AGENCY

I, _____, on behalf of _____,
(Name of Contact Person) *(Name of Agency)*

have been actively involved with the _____ applicant family since _____ *(date)* **and have assisted them in exploring all known service and funding options available in Durham Region. We recognize our role in relationship to case management/responsibility and the criteria for this funding.**

Signature: _____ Date: _____
(Agency Personnel)

SECTION II

Please ensure that your Proposal responds to the following questions and budget information. Feel free to include additional information that you feel would assist the committee. Your proposal will be evaluated on the basis of the information in this document.

The information you submit will be photocopied, so please ensure that it is legible.

1. Identify the diagnosis/condition of the applicant. Provide a description of the support needed by the individual on a daily basis. (***You may be asked to provide verification.***)

   _____

   _____

   _____

2. What are your goals for this application and how will it meet the needs or impact on the applicant and how does it meet the DSNAP criteria?

   _____

   _____

   _____

   _____

   _____

3. How do you intend to evaluate the impact on the applicant?

   _____

   _____

   _____

   _____

4. What will be the role of the family/caregiver in achieving these goals?

   _____

   _____

   _____

5. Are there services/supports that you have applied for and are currently on a "waitlist"?

   _____

   _____

6. Are there other services that you have applied for and were not accepted?

   _____

   _____

7. What other services/supports are currently being accessed and what is the level of involvement (what are they providing and how often)?

Agency/Service	Contact Person	Type Of Service	Frequency

8. What funds are you currently accessing (ie. S.S.A.H., O. D. S. P., annualized funding etc.) on behalf of the applicant? Full disclosure of all funding received from government or charitable sources is required in order to process your application. Incomplete applications will be returned.

Source	Amount	Purpose

9. Budget Submission: Please provide specific details of expected expenses.

STAFF (# of Hours) x (Rate of Pay) x (# of weeks) $ _____

OTHER _____
(Please identify other expected expenses.)

TOTAL REQUEST: $ _____

SECTION III

COMMUNICATION AGREEMENT

All application information is treated confidentially. In order to evaluate the application, respect your right to confidentiality, and to ensure accountability for public funds, it may be necessary to clarify some of the information contained. In order to proceed with your application we require authorization for release of information as outlined below.

I/we _____ of _____
(Applicant/Parent/Guardian) *(Address)*

understand that clarification and/or verification of information contained in the application may be required and within those limits, authorize the Durham Special Needs Allocation Program to contact/or be contacted by the individuals/agencies/services listed below:

ALL APPLICABLE FUNDERS MUST BE INITIALED

(Please initial)

[ ] Special Services at Home

[ ] ODSP

[ ] Other Ministry funding (including Passport)

[ ] other (please specify eg. Charitable funding)

_____

and

IDENTIFY and INITIAL ALL OTHER AGENCIES as appropriate:___

(Please initial)

[ ] _____

[ ] _____

[ ] _____

[ ] _____

[ ] _____

regarding _____D.O.B. _____
(Applicant's Name) *(mm/dd/yy)*

Unless otherwise noted, this authorization is valid for the period necessary to reach a decision (not to exceed 6 months) regarding the proposal dated _____ 20_____.

_____ _____
(Date) *(Signature of Applicant/Parent/Guardian)*

_____ _____
(Date) *(Signature of Witness)*

Information is collected under the authority of the Child and Family Services Act 7(1)(6).