ACSD
ASSISTANCE FOR CHILDREN WITH DISABILITIES

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What is ACSD?

- The **Assistance for Children with Severe Disabilities (ACSD)** program provides financial assistance to parents to help with extraordinary cost related to their child's disability.

- The child must qualify as having a severe disability. This is defined as an ongoing developmental or physical condition that results in functional loss. **Functional loss** refers to a major loss of ability, or capacity, to engage in any activity commonly considered necessary and appropriate to normal daily living; examples include walking, communication, self-feeding, dressing, personal hygiene etc.

- Income based funding source.

- Direct funding program. Funding is deposited into family's bank account on a monthly basis

- Funded and managed by the Ministry of Children, Community and Social Services.

What is ACSD?

- To be eligible, you must be the parent or guardian of an individual who:
  - Is under the age of 18 years old
  - Living at home with you
  - Has a severe disability

- The amount of ACSD funding that can be received is based on:
  - The size of your family
  - Total gross family income
  - Your yearly approved extraordinary expenses related to your child's disability

Family Size (Including Parents)	Full basic entitlement may be paid up to: (gross family income)	You may be eligible for some entitlement up to: (gross family income)
Up to 4	$42,000	$66,000
Up to 5	$43,000	$67,000
Up to 6	$44,000	$68,000
Up to 7	$45,000	$69,000

**As of September 2018*
(Subject to change)

What are Extraordinary Costs?

Examples are:

- Special learning and developmental equipment
- travel to doctors and hospitals
- special shoes and clothes
- parental relief
- wheelchair repairs
- assistive devices
- hearing aids
- hearing aid batteries
- Eyeglasses

- Items related to your child's vision and hearing may be covered, though you must get approval in advance from your Special Agreements Officer.

Please input parent information receiving the CCB.

Assistance for Children with Severe Disabilities

☒ Application ☐ Annual Report

Ministry to complete

Applicant/Spouse **Please complete both sides**

a) Applicant's Surname | Given Name(s) | Case Org. | Member I.D.

Address | Telephone Number

Postal Code

Date of Birth d m y | Verified ☐ yes ☐ no | Social Insurance Number ___-___-___ | Health Number

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Deserted ☐ Spousal

b) Spouse's Surname | Social Insurance Number ___-___-___ | Date of Birth d m y

Last name only

Ministry to check off

Child with the diagnosis

Dependants

Severely disabled child's name	Sex ☐ M ☐ F	Health Number	Date of Birth d	m	y

Does child spend any time in a hospital/institution? Please specify

Other Children Name	Sex M	F	Age	Name	Sex M	F	Age
	☐	☐			☐	☐	
	☐	☐			☐	☐	

Other children's names and ages

Family Income	Applicant	Spouse
(As reported on Income Tax Return for previous taxation year, 20)		
Income from: Employment (less employment expense deduction)	$	$
Pensions, Superannuation		
Maintenance, Alimony		
Rental or Boarder Income		
Family Allowance		
Unemployment Insurance		
Dividends, Interest		
Other Income from investments		
Other Income from Business/Property (explain)		
Other (specify)		
Sub-Total	(A)	(B)
Is applicant or spouse self-employed? ☐ Yes ☐ No If yes, state nature of occupation		
Does the severely disabled child have any income? ☐ Yes ☐ No If yes, specify source and amount (annual)		(C)
Total Family Income	**(Total A, B and C above)**	$

PLEASE PROVIDE NOTICE OF ASSESSMENT(S) FROM REVENUE CANADA

Fill in year noted on Notice of Assessment

Complete as required

If present family income is substantially different from previous taxation year, explain and, if necessary, attach detailed list of current income.

Has an application been made for Special Services at Home Program? ☐ Yes ☐ No

Check 'Yes' if applying today

Specialized Expenses for the Disabled Child

		Yearly
1.	**Regular Expenses**	
	Transportation Costs to doctor/clinic/hospital	$
	Babysitting (trained sitter)	
	Extra clothing, diapers, pants, linens	
	Special shoes/boots	
	Special diet	
	Extra laundry/cleaning costs	
2.	**Medical Expenses**	
	Equipment for hearing impaired	
	Drugs not covered by existing plan	
	Surgical supplies (not covered by A.D.P.)	
	Dental costs not covered by existing plan	
3.	**Educational and social expenditures**	
	Special learning/development equipment	
	Specialized day care (actual cost paid by parent)	
	Special education	
	Special summer camp fees	
	Parental relief program	

PLEASE COMPLETE THE ATTACHED SUMMARY OF EXTRAORDINARY EXPENSES

		Yearly
4.	**Other Expenses (specify)**	
	Necessary home repairs	$
	Repairs to special equipment/paid by parent (Itemize below)	
	Year Total	$

Note: Availability of, and use of, alternate sources should be listed, e.g. Blue Cross, Community/Provincial Agencies, Employees Insurance Plans.

Declaration

Print Parent's Name (receiving the CCB) Here

I, _____

am the applicant named on page 1, or the person making the application on behalf of the applicant.

I certify that all of the statements in the foregoing application are true to the best of my knowledge and belief and no information required has been omitted or concealed.

Should a benefit be granted to the applicant on the basis of the foregoing information, I undertake to notify the Director, or his representation, of any change in our circumstances, especially as they pertain to income, and to the residence of the children.

Dated this _____ day of _____ , 20 _____.

Today's Date

Witness Signs Here

Parent Signs Here

_____
Signature of Witness

_____
Signature of Applicant or person making application on behalf Of the Applicant

_____
Signature of Witness

_____
Signature of Spouse

Both parents should sign

Note: The *Ontario Disability Support Program Act, 1997* Sec. 59 states that a person who knowingly obtains or receives a benefit that he/she is not entitled to obtain or receive under the Act and the regulations is guilty of an offence.

Notice with Respect to the Collection of Personal information

(Freedom of Information and Protection of Privacy Act)

(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, sections 5, 10, 45 & 46, 59 or the Ontario Works Act, 1997, sections 7, 8, 15, 57 & 58 for the purpose of administering Government of Ontario social assistance programs.

This section states that it is important for you to fill in the forms truthfully and to the best of your ability.

ASSISTANCE FOR CHILDREN WITH SEVERE DISABILITIES
SUMMARY OF EXTRAORDINARY EXPENSES

Parent's Name: _____ Child's Name: _____

Parent and Child Names

Extraordinary costs are those costs directly associated with the child's disability, which are incurred above and beyond the normal cost of maintaining the child at home

REGULAR EXPENSES

Transportation and Doctor/Clinic/Hospital Costs

- Transportation may be considered when the purpose of the trip is to escort the child for treatment or medical care related to the disability
- You will be reimbursed at $0.40 per kilometre for the use of a private car
- Eligible transportation costs paid for TTC, taxi, etc. are allowable
- Please indicate if costs are covered under ODSP/OW or other agencies

# of Visits (per month or per year) x Cost + Parking = Yearly cost

	Doctor/Hospital (Please list address) year	# Of Visits per ~~Month~~	Method of travel (Car/TTC)	Approx. KM or Car/TTC Costs (Round-Trip)	Parking Cost	Yearly Cost	Ministry Use
Example 1:	Family Doctor 124 Jane Street	4	TTC	$6.50 x 4 visits	N/A	$26.00	
Example 2:	Neurologist 75 Queen Street	4	Car	20km x .40/km = 8 (8 x 4 visits)= $32	$10.00x4 =$40	$ 72.00	
Example 3:	Holland Bloorview 150 Kilgour Road	2	Taxi/ Uber	$50.00 round trip x2 visits = $100	N/A	$100.00	

Meal costs

- If you are at a medical appointment during a lunch hour, this cost may be reimbursed up to a maximum of $8.00 per person.

Location	Frequency	Cost	# Of People (Max 2)	Total Cost	Ministry Use
Example : Family Doctor	4	$8.00	2	$64.00	

Meals at appointment if over a lunch

Extraordinary Child Care and Babysitting Costs

- Babysitting for other children in the family (under age 12), while taking the child with a disability to a medical appointment, or a meeting related to the disability, may be included
- Example: I must pay a sitter an hourly rate to stay with my 2 younger children while I take my child with a disability to doctor appointments

Children	Ages	Cost per Hour	Length of Time per Visit	# of Visits per Year	Yearly Cost	Ministry Use
Example : Johnny & Jane	2 & 4	$20	3 hrs	5	$300	

Average length of time sitter is required

Total number of visits where you require a sitter

PERSONAL CARE COSTS

Specialized Expenses for the Child with a Disability	Yearly Costs	Ministry Use
Extra clothing Cost of additional clothing needed due to the child's disability (i.e. pants/tops/underwear/socks/jackets/snowsuits etc.) Please explain in detail why these items are required: Example: Extra pants (accidents) 3 extra/month @$15/each x 12months = (Do not include footwear in this section)	$540	
Other Clothing Costs Other items required due to the child's disability (i.e. bibs, bed linen, tailoring etc.) Please explain in detail why these items are required: Example: Extra Mattress pads (accidents) @$10 x 4 extras a year =	$40	
Diapers If your child is over 3 years of age and continues to require diapers, please contact the Easter Seals Society at 1-888-377-5437, to apply for the incontinence grant. ACSD will consider the parental portion not covered by Easter Seals. Example: 1 box diapers/month @ $30 x 12 months = $360 Your Total costs $ $360 Minus Easter Seals portion $ 0 Allowable Expenses $ $360	$360	

May be due to:
-Sensory issues – zippers, tags

-Chewing on neckline and sleeves

-Excessive wear – ripping clothes, wearing down knees of pants

-Multiple outfits per day

Examples:
- Linen for bed wetting
- Towels or bibs
- Altered clothing for medical equipment

Your child must be in diapers full time to be eligible for the Easter Seals portion.

Laundry Costs and Cleaning Supplies Additional laundry costs and cleaning supplies will be considered. Please list the number of extra loads, considering *3 loads per week is normal.* Please explain in detail why these items are required: **Example:** **2 extra loads/week @ $5/load = $10 x 52 weeks = $520** **1 extra Laundry detergent (additional laundry) per month @ $17 x 12 = $204**	**$724**	
Shoes/Boots/Orthotics Additional costs for shoes and/or boots directly related to the child's disability will be considered. *Four pairs of shoes and one pair of boots per year is considered normal.* Please explain in detail why these items are required: **Example: 1 extra pair of shoes (toe walking) @ $45.00**	**$45**	
Special Diet Any special diet related to the child's disability must be prescribed by a physician, and the Special Diet Application Form must be completed. (If you are in receipt of OW/ODSP, they will cover). If your child has *other* special diet requirements, please explain:		

Extra loads of laundry due to:
- Soiling
- Multiple clothing changes per day etc

May be due to:
- Dragging feet, toe walking
- Sensory issues
- Crawling and wearing out toes

May include:
- Dairy free diet
- Gluten free diet
- Pediasure/ Ensure

2. EDUCATION AND SOCIAL EXPENDITURES

***Extraordinary costs are those costs directly associated with the child's disability, which are incurred above and beyond the normal cost of maintaining the child at home.**

Specialized Expenses for the Child with a Disability	Yearly Costs	Ministry Use
Special Learning/Developmental Equipment: Please specify extraordinary costs for special learning and/or developmental equipment related to the disability (i.e. educational toys, books, videos, etc.). Up to $300.00 per year may be considered. Please explain: Example: Educational toys, books, videos, apps, puzzles	$300	
Special Education/Nursery School: Actual costs/fees paid by the parent for specialized preschool, (directly related to the child's disability) may be considered. *Verification/receipts to be provided.* Please explain:		
Camp Fees: Please specify the costs and name of the camp. *These must be specialized camps directly related to the child's disability. Would like to register if funds were available *Verification Required.* OR complete if registered already Name of the camp_____ Parent Cost_____ Start date_____ End date_____		

May include:
- •Educational books and toys
- •Music, DVDs, video games
- •Bicycle, sensory toys, etc

May include:
- •Special school or preschool
- •Special daycare
- •Tutoring services

Social Programs Expenditure: When the child participates in recreational or social programs and there are additional costs. *These expenses are to cover the extra cost of the specialized recreational or social programs related to the child's disability.* Please explain: **Would like to register if funds were available - example: swimming, karate, soccer** **OR** **Registered for Social Skills at Geneva Centre**	**$600**	
Parent Relief: Cost of respite/parent relief to allow parent(s) time away from additional responsibilities of caring for a child with a disability; may be considered up to a maximum of $150.00 per month. Please list the supplier of services, frequency, and costs of parent relief. (Please identify any relief provided by other programs) **Name of Worker:**_____ **If you currently have a worker, provide the name and telephone number of the Respite Provider.** **If you do not have a worker, please leave this section blank.**	**$2,160.00**	

May include:
- Social skills programs
- After school or Weekend programs
- Variety Village Membership etc

May include:
- A CHAP Respite Provider
- Respite programs

If you leave this section blank, you will receive a letter from your Special Agreements Officer stating you are eligible to receive a monthly amount once you find a Respite Provider and provide the name and phone # to your Special Agreements Officer.

MEDICAL EXPENSES

Specialized Expenses for the Child with a Disability	Yearly Costs	Ministry Use
Drug Costs Cost of non-prescription drugs related to a child's disability. Please explain in detail why this expense is required: **Example:** **1 bottle Multi-vitamins / 3mths @ $15 x 4 = $60** **1 bottle Omega 3/ month @ $20 x 12 = $240** **1 bottle Melatonin (difficulty sleeping)/month @ $12 x 12 = $144**	**$444**	
Equipment for Hearing Impairment Please include the expenses attributed to hearing impairment not covered by the Assistive Devices program (ADP) or private insurance. (Do not include the cost of moulds, repairs, or hearing aids, as these will be covered by the ACSD program with prior approval.) Please explain in detail why this expense is required:		
Medical/Surgical supplies Please specify any ongoing expenses related to the repair or maintenance of equipment related to the child's disability. Please explain in detail why this expense is required:		
Repairs to Special Equipment Any ongoing expenses related to the repair or maintenance of equipment related to the child's disability. Please explain in detail why this expense is required:		

May include:
- Vitamins
- Allergy medication
- Tylenol
- Stool Softeners
- Melatonin
- Eczema cream

May include:
- Hearing aid batteries
- Special head phones

May include:
- Gloves, sterile gauze, tape
- Bandages, tensor wraps

May include maintenance to:
- Wheelchair
- Walker or braces
- Tablet/iPad used for communication

OTHER EXPENSES

Specialized Expenses for the Child with a Disability	Yearly Costs	Ministry Use
Other Expenses Please list any other extraordinary expenses that are incurred as a direct result of the child's disability. Please explain in detail why this expense is required: **Example:** **Broken iPad screen (throwing) = $75** **Broken couch (excessive jumping) = $300** **Re-paint walls (colouring on walls) = $100**	**$475**	

May include:

- Damage to household items including painting walls
- Patching up holes in the wall
- Broken appliances
- ONLY items you have replaced!

Please provide any additional comments or information:

Date: _____

Parent/Guardian Name: _____

Parent/Guardian signature: _____

Parent Signs Here

Ontario

Ministry of Children, Community and Social Services

Assistance for Children with Severe Disabilities (ACSD)

Consent to Disclose and Verify Personal Information

I/We, _____

Full name of applicant/recipient

_____

Name of spouse

consent to the exchange of personal information between the Ministry of Children, Community and Social Services and

- an Ontario Works delivery agent
- the Government of Ontario or any agency, ministry or department of Ontario, such as the Ontario Disability Support Program
- any community agency or organization or service provider that provides services to us or for my/our disabled child(ren)

for the purposes of determining or verifying my/our initial and ongoing eligibility for financial assistance through the Assistance for Children with Severe Disabilities (ACSD) program under the Ontario Disability Support Program Act, 1997.

I/We understand that exchange of personal information means both the collection of personal information from and the disclosure of personal information to third parties for the purpose of determining verifying my/our initial and ongoing eligibility for the Assistance for Children with Severe Disabilities program and for administering my/our ACSD financial assistance.

I/We understand that this exchange of information may take the form of telephone conversations, face-to-face meetings, sending letters or records by mail or facsimile or electronic data exchanges.

I/We understand that this consent will apply to inquiries made relating to my/our initial eligibility for, as well as my/our past and ongoing receipt of the Assistance for Children with Severe Disabilities benefit.

I/We have read or had read to me and understand the consent set out above.

_____	_____	_____
Signature of Applicant/Recipient	Witness	Date
_____	_____	_____
Signature of Spouse	Witness	Date

Parent Name (receiving the CCB)

Parent Name (CCB)

Today's date

Ontario

Ministry of Children, Community and Social Services

Assistance for Children with Severe Disabilities (ACSD)

Consent to Recover Overpayments

Note to Applicant/Recipient

In order to receive financial assistance through the Assistance for Children with Severe Disabilities (ACSD), all applicants/recipients must agree to the recovery of any overpayments made to them. This form documents your agreement to this condition of eligibility.

It is an overpayment when you receive more financial assistance than you are entitled. If you receive an overpayment, the excess may be recovered through deductions at a rate of 2 per cent (2%) of your regular monthly payment until the overpayment has been recovered.

You can help avoid potential overpayments by notifying your Regional Office of any changes to your circumstances that may affect your entitlement immediately, including changes in disability-related expenses or household income.

As a person receiving financial assistance under the Assistance for Children with Severe Disabilities (ACSD), you may appeal an overpayment decision and you may appeal a decision to recover an overpayment to the Social Benefits Tribunal. Please contact your local Children, Community and Social Services office for further information on the appeal process.

As a condition of eligibility to receive financial assistance under the Assistance for Children with Severe Disabilities (ACSD) program, I, _____ agree that if an excess

Given Name, Surname

amount of financial assistance has been given to me, the Director may deduct that amount from any future financial assistance provided under the Assistance for Children with Severe Disabilities program to which I may be entitled.

Parent name (CCB)

Date and sign

_____ _____

Signature Date (dd/mm/yyyy)

O. Reg. 224/98, s 7. It is a condition of eligibility for financial assistance under this Regulation that the person receiving it agree that if an amount has been provided to the person in excess of the amount to which he or she was entitled, the Director may deduct that amount from any future financial assistance.

APPLICANT RESPONSIBILITES

If Approved for ACSD:

- You will be required to provide copies of your Notice of Assessment for yourself and spouse (if applicable) when requested.
- You may be required to complete periodic reviews of your expenses.
- You may be required to provide updated medical information.

You are to advise your Special Agreements Officer of any changes in your circumstances such as those listed below:

- If your family moves or your telephone number changes
- If your child enters a hospital, residence or institution
- If your child leaves your care
- If your marital status or family size changes
- If you leave the province for more than 30 days

Failure to comply with any of the above may result in the suspension of benefits or an overpayment on your file.

The amount of your benefit may vary year to year based on income and/or expense reviews.

It is your responsibility to keep copies of information submitted to our office. We will not provide photocopies.

PLEASE KEEP A COPY OF THIS APPLICATION FOR FUTURE REFERENCE

Ministry of Children, Community and Social Services

Toronto Region
375 University Ave, 5th floor
Toronto, ON M7A 1G1
Telephone : 416 325-0500
Fax : 416 325-9640
TTY : 416 325-360

Ministère des Services à l'enfance et des Services sociaux et communautaires

Région de Toronto
375, Ave University, 5e étage
Toronto, ON M7A 1G1
Téléphone : 416 325-0500
Téléc : 416 325-9640
ATS : 416 325-3600

Ontario

Dear Parent or Guardian:

Enclosed is an application for Assistance for Children with Severe Disabilities (ACSD). This program is a monthly benefit to help cover the **extraordinary costs related to a child's disability**. If eligible for ACSD, your child will automatically qualify for additional benefits, such as eyeglasses, mobility device repairs, and hearing aids, if necessary. Please see the reverse for eligibility criteria.

Please include ALL of the following information when applying, and keep a copy of your application for your records:

CHECKLIST

- ☐ **Application form** (enclosed)
  Must be signed and dated by Applicant (caregiver) and spouse if married or living common-law
- ☐ **Summary of Extraordinary Expenses** (enclosed)
- ☐ Signed and dated **Consent to Disclose and Verify Personal Information** (enclosed)
- ☐ Signed and dated **Consent to Recover Overpayments Form** (enclosed)
- ☐ Copy of **Applicant's Canadian Birth Certificate** OR Immigration Status in Canada
- ☐ Copy of **Child's Canadian Birth Certificate** OR Immigration Status in Canada
- ☐ Copy of **Child's Ontario Health Card**
- ☐ Copy of **medical documentation** that details the child's disability, signed by a Physician or a Psychologist (i.e. Psychological Assessment)
- ☐ Copy of most recent **Notice of Assessment** for Applicant and spouse/common-law partner (if applicable)
- ☐ Copy of most recent **Canada Child Benefit** (CCB)
  If you need copies of your Notice of Assessment and/or Canada Child Benefit, please contact the Canada Revenue Agency (CRA) at 1-800-959-8281.
- ☐ Direct Deposit Form from bank OR a void cheque

QUESTIONS?

respiteservices.com