

About the Special Services at Home Program (SSAH):

The SSAH program is focused on meeting needs broadly described as:

- **Personal Growth and Development** – These are individual developmental programs that are time limited and help the child achieve a specific goal.

and/or

- **Family Relief and Support** – This provides respite/relief for the caregiver and is related to support services in or out of the home of the family.

The SSAH program is available for children with a developmental and/or physical disability who are residents of Ontario. SSAH can help families with children with disabilities by providing time-limited funding to purchase supports and services not available elsewhere in the community.

The SSAH program serves children under 18 years and their families with a wide variety of needs. Information on this form may or may not apply to your individual situation. This form is not intended to replace regular contact between SSAH staff and families. You may be contacted if more information is needed.

Application Process:

The ministry has streamlined the application process for SSAH. If there is a significant change in circumstance, please contact your regional office.

This application may be submitted either by the individual requiring support, a parent or guardian.

The individual/family:

- may get help from a community agency or any other person to fill out this form;
- must sign the completed form to show it is true and correct; AND
- should never sign a blank application.

Please Note: that all decisions about SSAH funding amounts are based on your individual/family needs and supports, services available in the community, locally identified priorities, and the availability of SSAH funding within your ministry region.

Is this a new application or an update?				
<input type="checkbox"/> New Application <input type="checkbox"/> Update				
Person or Agency Assisting in the completion of application (If Applicable)				
Agency or Organization (if applicable)			Position	
Last Name		First Name		Middle Initial
Unit Number	Street Number	Street Name		PO Box
City/Town		Province		Postal Code
Telephone Number		Fax Number		

Applicant Requesting Support

Is the applicant legally entitled to live in Canada and a resident of Ontario?
(examples: citizen, landed immigrant, holder of a Minister's Permit, refugee entitled to live in Canada).

☐ Yes
☐ No

Date of SSAH Request (yyyy/mm/dd)

A copy of supporting documentation may be requested.

Last Name	First Name	Middle Initial
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (yyyy/mm/dd)
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Address

Unit Number	Street Number	Street Name	PO Box
City/Town			Postal Code
Telephone Number		Fax Number	

Mailing Address (if different from above)

Unit Number	Street Number	Street Name	PO Box
City/Town			Postal Code
Telephone Number		Fax Number	

Section 1 - Family Caregiver

Last Name	First Name	Middle Initial
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Relationship to Applicant

Address (if different from that of the applicant/individual requiring support)

Unit Number	Street Number	Street Name	PO Box
City/Town			Postal Code
Home Telephone Number		Work Telephone Number	

Section 2 - Individual and Family Update

Since your SSAH application was approved, has there been a significant change in the amount of assistance that is required in the following areas:

	No	Yes
i) Personal development e.g. communication, social skills, community activities	<input type="checkbox"/>	<input type="checkbox"/>
ii) Supervision at home, in the community or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>
iii) Behaviour	<input type="checkbox"/>	<input type="checkbox"/>
iv) Personal care	<input type="checkbox"/>	<input type="checkbox"/>
v) Health and/or medical care	<input type="checkbox"/>	<input type="checkbox"/>
vi) Family Situation	<input type="checkbox"/>	<input type="checkbox"/>
vii) Informal support network	<input type="checkbox"/>	<input type="checkbox"/>
viii) Other agency-sponsored supports	<input type="checkbox"/>	<input type="checkbox"/>
ix) Paid family relief and support	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "yes" to any of the questions above, please complete sections 3 to 8 (pages 3 to 7) of this application and return the completed form to your ministry regional office. You will be contacted regarding any changes to your funding.

Instructions to Complete Sections 3 to 8:

- Please complete all sections of the Application Form.
- All sections of the form are considered as a whole and are not listed in order of priority.
- If a section does not apply to your situation, please write "n/a" or draw a line through it.
- Keep in mind that the more complete your information is, the better we are able to assess your request for support.
- The application is an information gathering tool which collects information related to the seven decision-making factors for SSAH. It gives the individual/family an opportunity to state their needs and make a request.
- The personal information that is collected is confidential and is used for the purpose of providing you with services and support under the Special Services at Home program.

Supporting Documentation to Determine SSAH Eligibility

Documentation of the applicant's disability is required from a physician or psychologist, to establish basic eligibility.

- The documentation is (check one)
☐ attached ☐ previously sent (no change) ☐ will be sent separately
- The completed Progress Report is (check one)
☐ attached ☐ will be sent separately

Section 3 - Requests for Service

Please check the service or services you are requesting:

- ☐ **Personal Development and Growth:** These are individual developmental programs that are time limited and help the child achieve a specific goal.
- and/or

- ☐ **Family Relief and Support:** This provides respite/relief for the caregiver.

There are a number of services and supports that SSAH does not cover that include: basic care (e.g. food, clothing, diapers, baby sitting, child care, dental care and medical costs); child care fees; education activities usually provided by the Ministry of Education, assistive devices and professional fees. (Please consult the SAO for further info).

- a) If this is a request for Personal Development and Growth, please list the goals you wish to achieve. If the request is for a specialized area of programming (e.g. dealing with sign language or self-injurious behaviour) a copy of the program plan should be submitted.

1. _____
2. _____
3. _____
4. _____
5. _____

Total _____

If necessary provide additional details of cost estimate here

- b) Who will be responsible for receiving and managing the funds? (e.g. parent, agency)

Please provide agency's mailing address if not listed elsewhere in this application.

Agency's Mailing Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone Number		Fax Number	

Section 4 - Description of the strengths and interests of your family member and the support that you provide.

Decision-making for SSAH considers: a) how additional support will increase personal development and growth by complementing a person's strengths and interests, and b) the amount of support you provide to applicant. The program provides support to people who have a wide variety of unique needs. Please check or write in the factors that describe the applicant situation. The factors listed are only examples to help you complete the form. You can use these examples or add as appropriate. If needed, please attach additional sheets to describe your unique situation.

A. Strengths and Interests

To help us understand your family member's abilities, please describe their strengths and interests or add any other information you feel is important.

B. Personal Development Support

Check how often assistance is provided for personal development support

	Constant	Hourly	Daily	Weekly	Reminders	Never
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Activities / Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If appropriate, provide more information on your unique situation)

C. Supervision

Check the amount of supervision or attention provided for safety

	Constant	Hourly	Daily	Weekly	Reminders	Never
In the Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If appropriate, provide more information on the type of supervision provided)

D. Behaviour

Write in behaviour needs and check how often assistance is provided.

Examples are: - Aggression - Tantrums / Hyperactive - Self Injury - Destruction of property - Running Away
- Withdrawn behaviour - Behaviour that is significantly disturbing to self and/or others

	Several times daily	Once a day	Several times per week	Once a week	Sometimes
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If appropriate, provide more information on the type of supervision provided)

E. Personal Care		Write in personal care needs and check how often assistance is provided.				
Examples are:		- Dressing	- Eating	- Bathing	- Mobility	- Going to washroom/toileting
		- Lifting/transfers associated with personal care				
	Several times daily	Once a day	Several times per week	Once a week	Sometimes	Reminders Only
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If appropriate, provide more information on the type of supervision provided.)

F. Health and Medical		Write in the health and medical needs of your family member and check how often assistance is provided.				
Examples are:		- Catheterization	- Tube Feeding	- Seizure Control	- Suctioning, etc.	
	Several times daily	Once a day	Several times per week	Once a week	Sometimes	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(If appropriate, provide more information on the type of supervision provided)

Section 5 - Your family situation		
SSAH decision-making considers the unique needs of the family. The following are examples of special considerations that may affect your family's ability to support your son, daughter or family member.		
Please check the factors which apply to your situation.		
Factors	✓	Additional Comments
You are senior age parents / caregivers	<input type="checkbox"/>	
Other members of your family require care	<input type="checkbox"/>	
Your family member is on waiting list(s) for other services	<input type="checkbox"/>	
Only one parent can provide care	<input type="checkbox"/>	
You have extensive travel to services and supports	<input type="checkbox"/>	
You have extensive travel to appointments	<input type="checkbox"/>	
Other (Please specify) _____	<input type="checkbox"/>	
You may wish to provide us with other information about your unique situation that you feel is important for us to consider; (example: health of caregiver, changes to your family situation, number of children in your family, etc.)		

Section 6 - Support Networks that are available to you
SSAH decision-making considers the informal support that is available to the individual and family. Many families can count on help from others such as family, volunteers, neighbours, friends, etc. However, it is acknowledged that these supports can vary. What supports can you count on and how often are they available?

Section 7 - Paid Services and Supports

SSAH decision-making considers supports and services currently available and appropriate. The SSAH program does not duplicate existing community supports and it is expected that families will access available community services before considering Special Services at Home. What other sources of service or funding have you accessed or considered to meet the needs of your family member?

A.

Community Supports	Full Day (35-40 hrs./wk)	More than Half Day (21-34 hrs./wk)	Half Day (17-20 hrs./wk)	Less than Half Day (less than 17 hrs./ wk)	Applied to		Waiting List	Received Previously
					Yes	No		
Day Care (Formal or Informal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursery / Preschool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support Services (e.g. Infant Development, Behaviour Management, Health Support Services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Service Co-ordination / Case Management <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (e.g. Evening Program, City Recreation Program (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

B.

Family Relief and Support	Applied to		Yes Name the agency	How many hours per week?	No (Not currently receiving)	Received Previously
	Yes	No				
Parental Relief - In and Out of Home	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Nursing Respite	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Homemaking	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Other: e.g. Group Insurance (please specify)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Comments

C.

Other Financial Support

It is important that you (or your family member) seek the financial supports for which you are eligible.
Are you (or is your family member) in receipt of the following financial supports?

Type of Financial Support	Applied to		Ongoing		
	Yes	No	Yes	No	
Assistance for Children with Severe Disabilities (ACSD) (Formerly HCB for children under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If not eligible, please state reason

You may wish to provide additional documentation such as reports from other professionals if you feel it would help support your request.

Section 8 - Signatures**Additional Information:**

Additional information is often required before a request can be considered. However, if you do not wish to consent to release information at this time, draw a line through the blank spaces below. You may then sign below as an application only.

Consent for Release of Information

I give the Ministry of Children, Community and Social Services permission to obtain additional information regarding my application form from the organizations or individuals named below. (Examples: assisting agency/person, service provider, physician, psychologist, agency staff, etc.)

Signature of Applicant (If 16 years of age or older)		Or Signature of parent/guardian (if applicant is not capable of providing consent or is under 16 years of age)
Last Name	First Name	Telephone Number
Last Name	First Name	Telephone Number
Last Name	First Name	Telephone Number

Application

I hereby apply for services and declare that the above statements are true to the best of my knowledge.

Signature of Applicant (If 16 years of age or older)	Date (yyyy/mm/dd)
And/or Signature of parent or Guardian (If applicant is not capable to confirm statements or if under 16 years of age)	Date (yyyy/mm/dd)

Notice of Right to Review Decisions

You will be notified, in writing, of the decision made by the Ministry. If the request has not been approved as presented, and you feel that you have not been treated fairly according to the guidelines, you can ask for a review of this decision. To request a review, send a letter to the Regional Director/Administrator within 20 days after you have been notified of this decision.

Notice with Respect to the Collection of Personal Information

This information is collected for the purposes of administering the Special Services At Home Program funded under the authority of the *Child and Family Services Act*, R.S.O. 1990, c.C.11 and will be used to administer Special Services At Home Program to eligible individuals. If you have any questions concerning the collection of this information, please contact the following

Name of Regional Office Contact	Telephone Number
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Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone Number		Fax Number	

Regional Office Use Only

Recommended by	Date
Approved by	Date