Western Mary J. Wright Child and Youth Development Clinic

Fee Adjustment Application

Contact Information:

Client's Name: _____ **Date:** _____

Name of parent/legal guardian (if applicable): _____

Mailing Address: _____

City: _____ **Prov.:** _____ **Postal Code:** _____

Home Number: _____ **Cell Number:** _____

Email Address: _____

Best way to contact you: ☐ Home Phone ☐ Cell Phone ☐ Email

Please select the clinic **service type** from the options below and describe the **type of service** being provided.

☐ Psychological Services: (e.g. Assessments, Intervention, Workshops, etc.)

_____

☐ Speech and Language Services (e.g. Assessments, Intervention, Workshops, etc.)

_____

Household Composition:

Name	Relationship	Age	Monthly Income	Currently Employed?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Household Monthly Total $_____

Government Funding and Services

Please include all assistance you/your family is receiving: (Monthly Amount)

Ontario Works $_____

Tax Benefits $_____

Assistance to Children with Severe Disabilities (ACSD) $_____

Ontario Disability Services Program (ODSP) $_____

Veterans Affairs Canada (VAC) $_____

Workplace Insurance Workplace Safety & Insurance Board (WSIB) $_____

Government Funding and Services (Continued)

Please include all assistance you/your family is receiving: (Monthly Amount)

Other:_____ $_____

Other:_____ $_____

Other:_____ $_____

If you do not receive Ontario Works have you applied? Yes ☐ No ☐ Not eligible ☐

If you do not receive Tax Benefits have you applied? Yes ☐ No ☐ Not eligible ☐

If you do not receive ACSD have you applied? Yes ☐ No ☐ Not eligible ☐

If you do not receive ODSP have you applied? Yes ☐ No ☐ Not eligible ☐

If you do not receive VAC have you applied? Yes ☐ No ☐ Not eligible ☐

If you do not receive WSIB have you applied? Yes ☐ No ☐ Not eligible ☐

Do you receive any coverage through a private insurance plan? Yes ☐ No ☐

Has your family work status or income changed over the past year? Yes ☐ No ☐

If yes, please provide details below and how this impacts your financial situation.

_____

_____

_____

_____

Signatures:

I certify that the information provided on this application is true, correct, and complete to the best of my ability.

Parent/Guardian/Substitute Decision Maker _____ Date:_____

Please provide a copy of your most recent Notice of Assessment(s) from the Canada Revenue Agency and copies of your most recent cheque stub or statement of benefits for all active benefits.

Thank you for completing the application. The Administrative Officer will contact you within 3-5 days of the date the application was received.

Office Use ONLY

Reviewed date:_____ Signature:_____

Approval Type: _____

Criteria and eligibility are subject to change without notice by the Mary J. Wright Child and Youth Development Clinic.