



CANADA STUDENT LOANS PROGRAM

PROGRAMME CANADIEN DE PRÊTS AUX ÉTUDIANTS

APPLICATION FOR THE GRANT FOR SERVICES AND EQUIPMENT FOR STUDENTS WITH PERMANENT DISABILITIES

DEMANDE DE BOURSE SERVANT À L'ACHAT D'ÉQUIPEMENT ET DE SERVICES POUR ÉTUDIANTS AYANT UNE INCAPACITÉ PERMANENTE

PERSONAL INFORMATION - RENSEIGNEMENTS PERSONNELS

| | | |
|--|---------------------------|--|
| | | SIN - N.A.S. |
| Surname - Nom de famille | Given Name(s) - Prénom(s) | Date of Birth - Date de naissance Y - A M D - J |
| Address - Adresse | | City - Ville |
| Province | Postal Code - Code postal | Area code & Telephone No. - Indicatif régional et N° de téléphone |
| Name of Educational Institution - Nom de l'établissement d'enseignement | | Student Number - Matricule de l'étudiant |
| Course Load (no less than 40 % if full-time; no less than 20 % if part-time) Pourcentage de cours suivis (pas moins de 40 % pour un programme à temps plein et de 20 % pour un programme à temps partiel) | | |

EXCEPTIONAL EDUCATION-RELATED COSTS

NOTE: Support is limited to the services and equipment noted below and is dependent on the nature of the disability(ies). Check the appropriate boxes below:

DÉPENSES EXCEPTIONNELLES LIÉES AUX ÉTUDES

REMARQUE : L'aide est limitée aux services et à l'équipement énumérés ci-dessous et dépend de la nature de l'incapacité/des incapacités. Cocher les cases appropriées :

NATURE OF DISABILITY - NATURE DE LA DÉFICIENCE

Deaf, Hard of Hearing
Surdité, déficience auditive

Physical Disability
Déficience physique

ADD/ADHD
TDA/TDAH

Blind, Visually Impaired
Cécité, déficience visuelle

Learning Disability
Troubles d'apprentissage

Other (eg. head injury, mental illness). Specify:
Autre (p. ex. : traumatisme crânien, maladie mentale). Préciser : _____

SERVICES

Note Taker
Preneur de notes

Interpreter (oral, sign)
Interprète (oral, gestuel)

Tutor
Tuteur

Attendant for studies
Services d'auxiliaire pour les études

Reader
Lecteur

Specialized Transportation (to/from Institution only)
Transport adapté
(entre l'établissement et le domicile seulement)

EQUIPMENT - ÉQUIPEMENT

Technical Aids (eg. computer, braille). Specify:
Aides techniques (p. ex.: ordinateur, appareil de transcription en braille). Préciser :

Alternate Formats (eg. large or braille print)
Supports de substitution (p. ex. : gros caractères ou braille)

Computer/System Software/Accessories
Ordinateur/Logiciel/Accessoires

Learning Disability Assessment
Certificat attestant un trouble d'apprentissage

Other
Autre

THIS APPLICATION WILL NOT BE ASSESSED UNLESS ALL OF THE FOLLOWING DOCUMENTATION IS SUBMITTED WITH THIS FORM.

CETTE DEMANDE NE SERA PAS ÉVALUÉE SI LE FORMULAIRE N'EST PAS ACCOMPAGNÉ DE TOUTE LA DOCUMENTATION SUIVANTE.

A - PROOF OF ENROLLMENT

- A Canada Student Loans Program Certificate of Eligibility and Canada Student Loan Agreement (issued for the current academic year), signed by the designated educational institution at which you are enrolled; or,
- A Canada Student Loans Program Schedule 2, Confirmation of Enrolment Form, signed by the designated educational institution at which you are enrolled.

A - PREUVE D'INSCRIPTION

- un Certificat d'admissibilité et contrat de prêt d'études canadien du Programme canadien de prêt aux étudiants (c'est-à-dire un Certificat d'admissibilité délivré pour l'année scolaire en cours) signée par le responsable de l'établissement d'enseignement où vous êtes inscrit; ou
- une annexe 2 du Programme canadien de prêt aux étudiants (c'est-à-dire une Confirmation d'inscription) signée par le responsable de l'établissement d'enseignement où vous êtes inscrit.

B - STATEMENT OF DISABILITY

describing the type of disability and whether it is expected to be permanent.

- A medical certificate, OR
- A learning disability assessment, OR
- A document proving that you receive federal and/or provincial disability assistance.

B - PREUVE D'INCAPACITÉ

décrivant la nature et le caractère permanent de l'incapacité.

- Certificat médical; OU
- Certificat attestant un trouble d'apprentissage; OU
- Document prouvant que vous recevez des prestations d'invalidité fédérales et/ou provinciales.

C - CONFIRMATION OF NEED

for disability-related services or equipment. To be completed by one of the following:

- A Vocational Rehabilitation Services (VRS) case worker;
- An official at a centre for students with disabilities;
- A guidance counsellor or financial aid administrator at the post-secondary institution you are attending.

C - CONFIRMATION DU BESOIN

de services ou d'équipement en raison de votre incapacité. À remplir par l'une des personnes suivantes :

- un agent de traitement des cas des Services de réadaptation professionnelle (SRP);
- un responsable d'un centre pour étudiants handicapés;
- un conseiller d'orientation ou un administrateur de l'aide financière de l'établissement d'enseignement postsecondaire que vous fréquentez.

D - DETAILED COST ESTIMATES

(usually 2 separate sources) for the exceptional education-related costs identified above.

D - ESTIMATION DÉTAILLÉE DES DÉPENSES EXCEPTIONNELLES LIÉES AUX ÉTUDES

indiquées plus haut (faite habituellement par deux sources différentes).

FOR PROVINCIAL USE ONLY - RÉSERVÉ AUX AUTORITÉS PROVINCIALES

Assessed and qualifies for CSL/provincial assistance
A été évalué et jugé admissible à un prêt d'études du PCPÉ/à une aide provinciale

Institution Code
Code de l'établissement

| FOS Domaine d'études | No. of Wks of Study Nbre de semaines d'études | Period of Studies Période d'études | Period of Studies End Date Date d'expiration de la période d'études | Y - A M D - J | | |
|---|--|---------------------------------------|--|---------------|---|---------|
| | | | | Y | A | M D - J |
| Provincial Student Loan Approved Prêt d'études provincial approuvé | \$ | | Provincial Grant Approved Subvention provinciale approuvée | \$ | | |
| CSL Approved Prêt d'études du PCPÉ approuvé | \$ | | Federal Grant Approved Subvention fédérale approuvée | \$ | | |

Signature of Financial Aid Administrator
Signature du responsable de l'aide financière aux étudiants

Date (Y-M-D / A-M-J)

If I receive a grant for my exceptional education-related costs, I hereby agree to provide, by the end of my study period, receipts showing that funds were spent for their intended purposes.

Si je bénéficie d'une subvention au titre des dépenses exceptionnelles liées aux études, je consens, par la présente, à fournir à la fin de ma période d'études, des reçus prouvant que la somme a été dépensée aux fins auxquelles elle était destinée.

Student's Signature - Signature de l'étudiant

Date (Y-M-D / A-M-J)



Instructions for Completing MEDICAL ASSESSMENT FORM For Students with Permanent Disabilities

This form must be completed by a qualified medical assessor in order to verify the applicant's permanent disability and to determine eligibility for disability related financial grants and training goods and services while attending post-secondary education.

"Permanent Disability" means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life.

APPLICANT

- Complete Section A and Section B on page 2.
- Have the sections relating to your disability completed by the appropriate qualified medical assessor. For example, if you are visually impaired, your form should be completed by an Ophthalmologist or Optometrist. If you have a hearing impairment, your form should be completed by an Audiologist. Your limitations and barriers to your program of study must be clearly identified.
- If you have a **Learning Disability**, you must attach a current Psycho-Educational Assessment, completed in the last five years by a Registered Psychologist. Any other supporting documentation in reference to your learning needs would also be helpful.
- If you previously did not meet the disability criteria, were refused either because there was insufficient information provided to support your application, or your disability was not identified as permanent, or your documentation was not current, you must provide additional or current information from your medical assessor that clearly outlines the limitations and barriers that your disability will present while participating in studies at a post-secondary institution. Any previous medical documentation sent to our office is on file.
- Submit the completed form and any other supporting documentation to Student Financial Services.

MEDICAL ASSESSOR

This Medical Assessment Form will be used as one of the criteria to determine this student's eligibility to receive Canada Student Grant funding. Please ensure the diagnosis represents this student's permanent disability and lists the disability-related educational barrier(s).

- Please complete the appropriate section(s) pertaining to the permanent disability diagnosis.
- All medical assessors must complete all parts of Section J on pages 6 and 7, clearly describing the disability-related educational barriers and recommended interventions.

SECTION A PERSONAL INFORMATION

To be completed by the Student

Social Insurance Number _____

Date of Birth _____

YYYY / MM / DD

Last Name _____ First Name _____ Middle Initial _____

Address _____ Telephone Number _____

Civic (Street) Address or PO Box _____ Apt. No. _____ City/Town _____ Province _____ Postal Code _____

Name of Post-Secondary Educational Institution _____

Name of Program _____ You are in year ____ of a ____ program

Please check appropriate box

- This is my first time applying as a student with a permanent disability.
- I am appealing the previous decision of my disability status and I have provided the required information.

SECTION B STUDENT'S DECLARATION OF LIMITATIONS AND RESTRICTIONS

To be completed by the Student

Please explain how you will be restricted and/or experience a barrier in your ability to perform the daily activities to participate in studies at the post-secondary level or in the labour force.

Take this complete form to the appropriate medical assessor for completion and submission. Keep a copy of the completed form for your records.

MEDICAL ASSESSMENT FORM
For Students with Permanent Disabilities

IMPORTANT INFORMATION FOR MEDICAL ASSESSOR

Student Financial Services will use this Medical Assessment Form for Students with Permanent Disabilities as one of the criteria to determine this student's eligibility to receive federal grant funding and/or provision of disability training related goods and services. Please ensure the diagnosis represents this student's permanent disability and lists the disability-related educational barrier(s). Where applicable, indicate if the student's disability necessitates a reduced course load (less than 60% of a full course load), even with the recommended supports.

"Permanent Disability" means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life.

PLEASE COMPLETE THE APPROPRIATE SECTION THAT PERTAINS TO THE STUDENT'S DISABILITY.

Note: Section J on pages 5 and 6 must be completed by the medical assessor for all applicants.

Completed forms are to be mailed to: Student Financial Services
Department of Education and Lifelong Learning
P.O. Box 2000, 176 Great George Street
Atlantic Technology Centre, Suite 212
Charlottetown, PE C1A 7N8

Print first and last name of the student being diagnosed.

Last Name _____ First Name _____

SECTION C PHYSICAL DISABILITY

To be completed by a Physician

Examples: arthritis, spinal cord injury, spina bifida, Crohn's disease, back injury, etc.

Primary Diagnosis:

Please complete Section J on pages 6 and 7.

SECTION D HEARING IMPAIRMENT

To be completed by a Certified Audiologist

I certify this client to be hearing impaired according to the following criteria. Indicate appropriate description.

Level of hearing loss in the better ear. Indicate appropriate descriptions.

Part A Mild Moderate Profound Severe

Part B

- Hearing loss interferes with student's learning
- Uses hearing aids
- Would benefit from amplification devices in an educational/vocational setting

Attach a copy of a recent Audiogram. Please complete Section J on pages 5 and 6.

SECTION E VISUAL IMPAIRMENT

To be completed by an Ophthalmologist or Optometrist

I certify this client to be visually impaired according to the following criteria. Indicate appropriate description.

- A visual acuity of 6/21 (20/70) or less in the better eye after correction
- A visual field of 20 degrees or less
- Any progressive eye disease with a prognosis of becoming one of the above within the next two years
- Near point vision for print reading of _____

Diagnosis:

Please complete Section J on pages 5 and 6.

SECTION F NEUROLOGICAL DISABILITY

To be completed by a Neurologist, Psychiatrist or Physician

Examples: cerebral palsy, epilepsy, multiple sclerosis, brain tumour, stroke, head injury

Primary Diagnosis:

Medication and side effects, if applicable:

Please complete Section J on pages 6 and 7.

SECTION G ADD / ADHD

To be completed by a qualified Physician or Psychologist

I certify this client to be ADD / ADHD according to the following criteria. Indicate appropriate description.

Diagnosis according to DSM-IV criteria and background history is (please provide details in Section J):

- ADHD Inattentive Type
- ADHD Impulsive-Hyperactive Type
- ADHD Combined Type

Medication and side effects, if applicable:

Attach a copy of a current Psycho-Educational Assessment.

Please complete Section J on pages 6 and 7.

SECTION H PSYCHIATRIC DISABILITY

To be completed by a Clinical Psychologist, Psychiatrist or Physician

Example: Mental Health Consumer

Primary Diagnosis according to DSM-IV criteria

Medication and side effects, if applicable:

Please complete Section J on pages 6 and 7.

SECTION I OTHER DIAGNOSED DISABILITIES

To be completed by the appropriate medical assessor

Examples: Developmental Disability, Cognitive/Intellectual, Autism Spectrum Disorder

Primary Diagnosis:

I certify this applicant to have _____ based on the following

- Psycho-Educational Assessment – attach a copy
- Medical Assessment
- Other – please specify _____

Please complete Section J on pages 6 and 7.

SECTION J ALL MEDICAL ASSESSORS MUST COMPLETE ALL PARTS OF THIS SECTION ABOUT THE APPLICANT

Part A Disability Determinants

Print first and last name of the student being diagnosed.

Last Name _____ First Name _____

Is this student a regular patient of yours? Yes No

If yes, how frequently have you met with this individual in the past two years? _____

Primary Disability Diagnosis:

Is the disability permanent Yes No

Is the disability Mild Moderate Severe Very Severe

Secondary Disability Diagnosis, if applicable:

Is the disability permanent Yes No

Is the disability Mild Moderate Severe Very Severe

Medication and side effects, if applicable:

Part B Functional Limitations (please print clearly)

“Permanent Disability” means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person’s expected natural life.

In the space below, please identify and describe in detail what functional limitation(s) result in a restriction and/or barrier(s) that limit the ability of the student to perform the daily activities necessary to participate fully in post-secondary studies or the labour force.

Attach additional sheet, if necessary.

SECTION J con't.

Part C Medical Assessor Information

I certify that the information provided on this form is accurate and the student identified in this assessment experiences the disability-related educational barriers indicated.

Name of certifying Medical Assessor (please print) _____

Address _____ Telephone Number _____

Civic (Street) Address or PO Box _____ Apt. No. _____ City/Town _____ Province _____ Postal Code _____

Signature (must be signed in ink) _____ Date _____
YYYY / MM / DD

Registration I.D. _____

Please forward all pages of this form to the address below.

It would also be beneficial for the applicant to have a copy of the completed form for their records.

Student Financial Services
Department of Education and Lifelong Learning
P.O. Box 2000, 176 Great George Street
Atlantic Technology Centre, Suite 212
Charlottetown, PE C1A 7N8

**APPLICATION for Canada Student Grant for Services & Equipment
for Students with Permanent Disabilities**

This form must be completed by your Educational Institution

Student Information

| | | | |
|---|---------------------|-----------------|---|
| Social Insurance Number ____ - ____ - ____ | Name of Institution | Name of Program | Course Load ____ % <small>100 % = 5 credits or a full program</small> |
| First Name | Last Name | Date of Birth | |
| Address (number and street) | | | Apartment Number |
| City, Town, or Post Office | Province | Postal Code | Area code and telephone # |

Nature of Disability

| | | | |
|---|--|--|--|
| <input type="checkbox"/> Deaf, Hard of Hearing | <input type="checkbox"/> Blind, Low Vision | <input type="checkbox"/> Physical | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Chronic Illness (MS, Crohn's, Diabetes, Lupus, etc.) Please specify: | |
| <input type="checkbox"/> Other (Head Injury, Cerebral Palsy, Cognitive, Autism Spectrum, etc.) Please specify: | | | |

Education-Related Costs to be Covered

| | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Tutors / Readers | <input type="checkbox"/> Note Takers | <input type="checkbox"/> Interpreters | <input type="checkbox"/> Attendant for Studies |
| <input type="checkbox"/> Specialized Transportation (to/from Institution only) | <input checked="" type="checkbox"/> Computer/Assistive software/Assistive accessories (Equipment) | | |
| <input type="checkbox"/> Technical Aids/Equipment (CCTV's, FM's, etc.) | <input checked="" type="checkbox"/> Learning Disability Assessments (Services) | | |
| <input type="checkbox"/> Other:(Please specify): | | | |

Institutional Disability Services Administrator's Approval (DRF, Student Services, Registrar)

I have verified the student's disability and reviewed the educational-related costs to be covered. I hereby confirm the student's need for the education-related accommodations and services at the costs indicated on the enclosed form. Cost estimate(s) have been provided. I also confirm that the above-named student is enrolled and registered at this institution for the current study period.

Print Name: _____ **Position:** _____
Disability Services Administrator

Signature: _____ **Phone#:** _____ **Date:** _____
Disability Services Administrator

Student's Declaration

I require this assistance to cover the cost of the educational accommodations and/or services related to my disability(ies) as noted above. I understand that I may be required to repay all or part of this assistance if the information is found to be inaccurate for any reason or if my study period and/or my course load changes. I understand that if I fail to provide receipts or return excess funding, that I may be disqualified from future assistance. I hereby agree to provide, by the end of my study period, receipts showing that funds were spent for their intended purposes.

Student's Signature: _____ **Date:** _____

All personal information is collected under the authority of Section 31(c) of the Prince Edward Island Freedom of Information and Protection of Privacy Act RSPEI 1988 Cap.F-15.01, the P.E.I. Student Financial Assistance Act and Regulations, and the Canada Student Financial Assistance Act and Regulations, as it relates directly to and is necessary for the administration of the Canada Student Loans Program and the Prince Edward Island Student Loan Program and will be used for the determination of financial assistance and for the purposes of determining and verifying eligibility, entitlement for, and the general administration and enforcement of the Canada Student Grants. If you have questions regarding the collection of information please contact the Financial Awards Officer with Student Financial Services at PO Box 2000, Atlantic Technology Centre, 90 University Ave Suite 212, Charlottetown, PE C1A 7N8. Telephone: (902) 368-4640, Fax: (902) 368-6144.



SERVICES REQUEST FORM

***Tutoring, note taking, reader, attendant care,
interpreting services, alternate format***

The information on this form will be used for processing your requests for services funding that may be available through the Canada Student Grant for Services and Equipment for Persons with Permanent Disabilities. Please use a separate form for each type of service request.

The application cannot be processed without the Name of Services Provider completed.

Name of Student: _____ Social Insurance Number _____

Service Request: _____

| FIRST TERM | | | | | SECOND TERM | | | | |
|-------------------------------|----------|---------|---------|-------|--------------------------------|----------|---------|---------|-------|
| Course | Hrs/Week | # Weeks | \$/Hour | Total | Course | Hrs/Week | # Weeks | \$/Hour | Total |
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| | | | | | | | | | |
| First Term Total Costs | | | | | Second Term Total Costs | | | | |

*I understand that my approved services funding may be issued in installments. The second installment, if required, will only be issued **when it is requested**, and **the request is accompanied with the receipts** showing the first installment usage. Receipts must show dates and hours of usage.*

Signature (must be signed in ink) _____

Disability Services Administrator: _____

Name of Services Provider _____

Date _____