





# Application to the Assistive Technology Support Program

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## Funding request

The SMD Assistive Technology Support Program will refund a portion of the purchase price of the technology / device(s) that you have purchased. Please itemize the costs related to the purchase of the technology / device below.

Purchase price: \$ \_\_\_\_\_

Shipping costs (if applicable): \$ \_\_\_\_\_

Installation costs (if applicable): \$ \_\_\_\_\_

Training costs (if applicable): \$ \_\_\_\_\_

Yes     No

Were any other organizations contacted regarding funding for these items?  
If yes, please advise what group(s) were contacted.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Please advise of any other funding received for these items including amounts:

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The funding through the SMD Assistive Technology Support Program is designed to assist in refunding a portion of the costs that a person has **already paid** to purchase assistive technology.

**CLEAR & LEGIBLE COPIES OF ITEMIZED RECEIPTS FOR THE COSTS BEING SUBMITTED FOR FUNDING MUST ACCOMPANY THE APPLICATION.**





# Application to the Assistive Technology Support Program

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## References

Please provide us with the names of three references that can support your stated need for this technology / device. *(These can be family members, friends, medical personnel, case workers, or anyone that knows of your situation.)* (HINT: a variety of people is always preferred)

1. Reference name:	
Mailing address:	
City:	Postal Code:
Home telephone:	Day time telephone (if different):
Email:	

2. Reference name:	
Mailing address:	
City:	Postal Code:
Home telephone:	Day time telephone (if different):
Email:	

3. Reference name:	
Mailing address:	
City:	Postal Code:
Home telephone:	Day time telephone (if different):
Email:	

Remember you must be a member in good standing of SMD Alliance in order to be eligible for funding through the SMD Assistive Technology Support Program.

We would like to invite you to learn more about our SMD Foundation/Easter Seals programs and services including the Information Services Program and the various means of which we raise funds to support programs such as this. We would like to add your name to our mailing list. This is **not** a mandatory requirement for funding approval and will in no way effect your application. If you prefer not to have your name added, please tick here:



### Application for Membership to SMD Alliance

Anyone, and in the case of a child the parent or legal guardian of the child, who has received within the two years prior to application for membership, services offered by or through the Society for Manitobans with Disabilities Inc.; or anyone with a disability who is a member in good standing of a corporation or other organization which has signed a participation agreement with SMD Self-Help Clearinghouse Inc. may apply for voting membership.

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**Name:**  
(Mr./Mrs./Ms.) \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Telephone: (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_  
**Email:** \_\_\_\_\_

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Please complete either (a) OR (b) below:  
(a) the SMD program(s) from which you have received service (Please specify)  
\_\_\_\_\_  
\_\_\_\_\_

(b) the name of the organization, participating in the SMD Self-Help Clearinghouse, of which you are a member (Please specify)  
\_\_\_\_\_  
\_\_\_\_\_

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Membership Term:     one year (\$5.00)     two year (\$10.00)     three year (\$15.00)

Method of Payment (enclosed):  
 Cash    Cheque (payable to SMD Alliance)     Visa    MasterCard

Cardholder's Name: \_\_\_\_\_  
Credit Card Number: \_\_\_\_\_  
Expiry Date: \_\_\_\_\_  
Cardholder's Signature \_\_\_\_\_

I wish to join SMD Alliance, but am unable to pay the fee at this time.