Assistive Technology Support Program

Fact Sheet

Eligibility Requirements

Client/consumer of SMD can apply each year if:

- ☐ Assistive Technology device(s) is purchased between Apr. 1 – Mar. 1
  Copies of paid invoices must be attached to the application.

- ☐ Application is received by Mar. 1
  Applications are reviewed by the AT Committee on a first-come, first-served basis. Support is subject to AT Committee approval and availability of funds. AT Committee decisions are explained in writing and are final.

- ☐ Applicant becomes a member of SMD Alliance

NOTE: Applicants that have received the maximum $2,500 in funding from the program within the current year are not eligible for additional funding.

Application Submission

Completed application forms can be submitted by mail or email to the following:

Society for Manitobans with Disabilities
825 Sherbrook Street
Winnipeg, MB R3A 1M5
Attention: Assistive Technology

P: **204-975-3010**
E: AT@smd.mb.ca

Application to the Assistive Technology Support Program

APPLICANT INFORMATION

The following information is required about the person that will be regularly using the assistive technology or device(s).

Name:	
Mailing address:	
City:	**Postal Code:**
Home Telephone #: _____ **Cell Phone #:** _____ **Work Phone #:** _____	
Email:	
Preferred communication by: ☐ **telephone** ☐ **email** **OR** ☐ **through Advocate** *(listed below)*	
What is your age group? ☐ Children & Youth (1-17 years) ☐ Adults (18 - 64 years) ☐ Seniors (65 years and over) ☐ Prefer not to share	
Do you _____ **Own or** _____ **Rent your current residence?**	

Advocate/Legal Guardian/Substitute Decision Maker for applicant

If this application is being submitted by another person on behalf of the individual named above, please provide your information.

Name:	
Mailing address:	
City:	**Postal Code:**
Home telephone:	**Day time telephone (if different):**
Email:	

ASSISTIVE TECHNOLOGY OR DEVICE(S) DESCRIPTION

Please describe the technology or device that you need; include manufacturer, model and other details.

Please tell us why this technology/device is important to you and what you want / intend to achieve with it. *(HINT: Tell us what this has done for your independence, lifestyle, ability to work….. etc)*

FUNDING REQUEST

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

Purchase price: $_____

Shipping costs (if applicable): $_____

Installation costs (if applicable): $_____

Training costs (if applicable): $_____

Were any other organizations contacted regarding funding for these items? ☐ Yes ☐ No
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:

_____

_____

_____

_____

_____

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.

APPLICATIONS WILL BE REVIEWED BY THE ASSISTIVE TECHNOLOGY COMMITTEE AND ALL DECISIONS MADE ARE FINAL.

I _____ declare that the assistive technology/device has been purchased for my sole use and that I had to cover a portion or all of the resulting costs of the assistive technology or device.

Signature of Witness	**Signature of Applicant**
Print Name of Witness	**Print Name of Applicant**

I represent that I am a parent/guardian/advocate or substitute decision maker of the Applicant who has signed the application form for the SMD Assistive Technology Support Program.

Signature of Witness	**Signature of Parent/Guardian/Advocate/Decision Maker**
Print Name of Witness	**Print Name of Parent/Guardian/Advocate/Decision Maker**

REFERENCES

Please provide us with the names of three references that can support your stated need for this technology or device(s). *(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:	

We would like to invite you to learn more about our programs and services by checking out our website (www.smb.mb.ca).

☐ Please fill out the check box to join our mailing list. This is not mandatory nor will it have any effect on your funding approval.

APPLICATION CHECKLIST

***Please check** each box once you enclose the item. Failure to provide a fully completed application form or the necessary supporting documents will result in the return of your application. If you have any questions, please call 204-975-3010 for clarification.*

- ☐ **Assistive Technology Application Form (*fully completed and signed*);**
- ☐ **Copy of receipts *paid in full* to support your request;**
- ☐ **SMD Membership Application Form with $5.00 (cash or cheque) OR your SMD Membership Number: _____**

For office use only:

☐ **Approved** **Date Approved:** _____ **Amount Approved: $**_____

☐ **Declined**

Reason for Decline: _____

_____

_____

_____

_____

_____