Shoreline Speech Therapy

CONTINUING CARE SPEECH THERAPY BURSARY PROGRAM
APPLICATION

Shoreline Speech Therapy is currently accepting applications for the Speech Therapy Bursary Program. This program is for residents of continuing care facilities in the Dartmouth area (including Halifax and Eastern Passage) who experience barriers to accessing treatment for a communication disorder:

(a) inability or significant hardship to travel to service locations, **and**
(b) financial barriers (those with only $500 of insurance coverage are still eligible)

The bursary provides for:

(a) full communication assessment
(b) block of treatment (up to a maximum of 6 months; depends on resident's needs)
(c) treatment provided at the individual's place of residence
(d) communication partner training (if applicable)
(e) all assessment and treatment materials

Process:

1. Complete the attached application form. We require a health professional (e.g., social worker, registered nurse, nurse practitioner, physician) who is familiar with the resident to vouch for the resident's candidacy for this program.

2. If you are contacting Shoreline on behalf of a resident and you are not their substitute decision maker, you must have the consent of the resident or their SDM.

3. Send the application to Shoreline Speech Therapy:

Pamela Coulter, M.Sc., S-LP(C)
Shoreline Speech Therapy
300 Prince Albert Road, Suite 215
Dartmouth, NS, B2Y 4J2
phone (902) 219-3065 | (902) 405-7858
fax (902) 704-5444
pcoulter@shoreline-speech.com

Shoreline Speech Therapy

CONTINUING CARE SPEECH THERAPY BURSARY PROGRAM APPLICATION

Person(s) completing this application:

- ☐ Resident
- ☐ Substitute Decision Maker
- ☐ Health professional (with consent of resident or SDM)

Resident Information

Name _____ Date of Birth _____ Gender _____

Place of Residence _____ Phone Number _____

Street Address _____ Alternate Phone Number _____

City/Town _____ Province _____ Postal Code _____

Substitution Decision Maker Information (if applicable)

Name _____ Relationship to Resident _____

Street Address _____ Phone Number _____

City/Town _____ Province _____ Postal Code _____ Alternate Number _____

Email _____

Health Professional's Information

Name _____ Profession _____

Work Address _____ Phone Number _____

City/Town _____ Province _____ Postal Code _____ Alternate Number _____

Email _____

Consent

If this application is being submitted on behalf of a resident or their substitute decision maker, please complete this section.

☐ I have provided consent for _____
name of professional

to submit this application on my behalf.

_____ _____
print name signature

Declaration

This section must be completed by a health professional.

☐ I declare that the applicant meets the criteria for this bursary.
- inability or significant hardship to travel to service locations (public or private), **and**
- financial barriers to accessing on site private services (those with only $500 of insurance coverage are still eligible)

_____ _____
print name signature

Information About Resident

This section may be completed by the applicant, substitute decision maker, or a health professional. More detailed information will be collected by the S-LP providing the service.

Please briefly describe the nature of the communication disorder.

_____

_____

Briefly, what would you like to achieve from services from an S-LP?

_____

_____