



Cerebral Palsy Association of Manitoba (CPAM)

PERSONAL SUPPORT WORKER PROGRAM APPLICATION September 2009 to August 2010

Name of Adult: _____

Date of Birth: _____ 2009 -2010 membership with CPAM: Yes ___ No ___

Address: _____

Postal Code: _____ Phone Number: _____

Cell Phone: _____ E-mail: _____

Name of Person completing the application, if different from above:

Relationship to Member: _____

Address: _____

Postal Code: _____ Phone number: _____

Cell Phone: _____ E-mail: _____

Provide a brief description of the ways in which the applicant might use this service – i.e. social event, recreation, shopping, trip/holiday

It is important to read all the information about this PROGRAM and complete and sign all the documents. You can call the office at 982-4811 or 1-800-416-6166 for assistance. Complete page 1 & page 5 and return both of them to CPAM, 105-500 Portage Ave. Wpg., MB. R3C 3X1. This is a “first come, first served” basis so apply right away. IT IS IMPORTANT FOR YOU TO KEEP PAGES 2, 3, & 4 TO REFER TO FOR INFORMATION ON THIS PROGRAM AND PAYMENT OF FUNDS FROM THIS PROGRAM. COMPLETE & RETURN THIS PAGE

1.0 THE PERSONAL SUPPORT WORKER PROGRAM FOR 2008 - 09

1.1 The Personal Support Worker Program (the “Program”) is a program, the aim of which is to provide some financial assistance to adult members of CPAM (the “Member”) who wish to make use of the services of another individual (the “Support Worker”) to support him/her in ways which contribute to his/her physical, social, emotional, or spiritual well being (the “Services”).

1.2 The Member or his/her family or other designate (collectively referred to as the “Applicant”) are solely responsible for the purchase, management and administration of the Services. Applicants are encouraged to select persons with whom they are familiar, and in whom they feel confidence in having their needs met. Criminal record checks, child abuse registry checks and/or character references are the responsibility of the Applicant to obtain as the Applicant considers necessary.

2.0 FUNDING

2.1 Funding for this program has been made available through the fundraising efforts of CPAM and its many community supporters. As funding is limited in the amount which can be distributed each year, requests will be dealt with on a **‘first come, first served’ basis until the annual budgeted funds are exhausted.**

2.2 Applicants accepted by CPAM into the program will be eligible to receive funding limited to a **total of 48 hours in each fiscal year. CPAM will provide \$9.00 per hour towards payment of a Support Worker. A 24 hour period will be compensated at \$170.00**

3.0 PAYMENT

3.1 There are two ways in which the Support Worker can be paid:

- a) CPAM may issue a cheque directly to the Support Worker.
- b) The Applicant may pay the Support Worker directly and apply to CPAM for reimbursement.

In either circumstance the Applicant will be required to submit a **SUMMARY OF HOURS WORKED SHEET** to the CPAM office. The worksheet shall be in a form provided by CPAM and will document the name of the Support Worker together with contact information, the date on which Services were provided and the hours worked. **WORK SHEETS** shall be **signed by both the Support Worker and Applicant** and shall be submitted to CPAM **not more than 30 days following performance of the Services.**

Where the Applicant /CPAM Member pays the Support Worker directly, the Support Worker will also be required to provide a signed receipt or paper confirming proof of payment WHICH NEEDS TO BE ATTACHED TO THE SUMMARY OF HOURS WORKED SHEET.

3.2 The Applicant shall submit the signed worksheet not more than 30 days following performance of the services.

3.3 CPAM will endeavor to pay amounts due under the Program within 30 days after receipt of properly completed worksheets.

4.0 ACCEPTANCE AND TERMINATION

4.1 CPAM has the sole discretion to accept or reject an application for any reason it deems appropriate.

4.2 CPAM may terminate the Program or an Applicant's participation in the Program at any time by giving the Applicant 7 days notice in writing.

4.3 Without restricting CPAM's rights under Article 4.2, and without restricting any other rights or remedies available to it, CPAM may terminate an Applicant's participation in the Program immediately and without Notice if in the sole opinion of CPAM the Applicant has failed to comply with a term or condition of the Program as set out herein or if the services retained by the Applicant are unsatisfactory, inadequate or improperly performed and/or are not being performed in keeping with the spirit of the program.

4.4 Upon termination, CPAM shall have no obligation to make payments as set out in Article 3 other than for Services satisfactorily performed (and for which complete and satisfactory documentation has been submitted within the permitted timelines) prior to the date of termination.

4.5 CPAM reserves the right to conduct follow-up interviews with Applicants, Members and Support Workers after payment of funds is made to confirm that program funding has been used appropriately.

5.0 LIABILITY AND INDEMNIFICATION

5.1 The Applicant shall use due care in the performance of the obligations under the Program to ensure that no person is injured, property damaged or rights infringed.

5.2 The Applicant shall be solely responsible for the selection of their own Support Workers and shall use due care in selecting, training, instructing, or carrying out activities involving the Support Worker. CPAM is not responsible for issues arising between the Applicant and the Support Worker and is not liable for any difficulties with suitability, safety, workmanship or any matters related to services rendered through the funds provided by this Program.

5.3 The Applicant shall be solely responsible for:

- a) any injury to persons (including death), damage or loss to property or infringement of rights caused by or related to participation in the Program or breach of any term or condition of the Program by the Applicant, Member or their employees, contractors or agents;**
- b) any omission, negligent or wrongful act of the Applicant, the Member or their employees, contractors or agents;**
- c) and the Applicant shall release, save harmless and indemnify CPAM, its officers, employees and agents from and against all claims, liabilities and demands with respect to clauses a) & b).**

GENERAL PROVISIONS

6.1 This Application, if accepted by CPAM shall constitute a binding Agreement between CPAM and the Applicant, the consideration for which and sufficiency of same is acknowledged by the parties.

6.2 Article 5 shall survive termination of the Program and this Agreement.

6.3 The Applicant shall not assign or transfer this Agreement without first obtaining written permission from CPAM.

6.4 This Agreement does not create the relationship of employer and employee or of principal and agent between CPAM and the Applicant or between CPAM and the Support Worker.

6.5 This document contains the entire agreement between the parties. No amendment, change or modification of this agreement shall be valid unless in writing and signed by both parties.

INSTRUCTIONS:

1. Fill out all areas of the **application (cream coloured paper –pg.1)** and send it to CPAM with the **signed Agreement AND Privacy Provision (blue coloured paper –pg.5)**. **Keep pages #2-4 in a safe place so you have the information on this program.**
2. After you have sent in your Application form and Agreement then phone or email CPAM office to notify staff of the date you are planning to use the services of a support worker and to have a **SUMMARY OF HOURS WORKED SHEET** mailed to you.
3. Follow the directions on **page #2** under **PAYMENT** and send in the **filled out and signed Summary of Hours Worked sheet** to CPAM – 105-500 Portage Ave. Wpg. MB. R3C 3X1. If you, the Member, are to be reimbursed **BE SURE** the bottom portion of the **Summary of Hours Worked has been signed** confirming that you have paid the Support Worker. **PROVIDE A RECEIPT/PROOF OF PAYMENT.**

**Cerebral Palsy Association of Manitoba
105-500 Portage Ave., Winnipeg, MB.
R3C 3X1**

982-4911 or 1-800-416-6166
[**lauras@cerebralpalsy.mb.ca**](mailto:lauras@cerebralpalsy.mb.ca)

AGREEMENT 2009-10:

“I HAVE READ THE ENCLOSED INFORMATION AND AGREE TO ABIDE BY THE TERMS AND CONDITIONS OF THE PROGRAM”

WITNESS

APPLICANT

DATE _____

PRIVACY PROVISION:

As part of CPAM’s ongoing commitment to the protection of our members’ privacy, this is to inform you that any personal information collected for the purposes of the Personal Support Worker Program will be kept in the strictest confidence and will be used or disclosed only for the purposes of this program. By completing this application form, you hereby consent to the collection, use, and disclosure of your personal information by the CPAM as needed for the running of this program. Where the Applicant and Member are not the same person, the Applicant represents that he/she is authorized to provide such consent on his/her own behalf and on behalf of the Member.

I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE DESIGNATED USE OF PERSONAL INFORMATION FOR THE PURPOSES OF PARTICIPATING IN THIS PROGRAM.

Applicant: _____ **Print Name** _____

Date: _____