Ontario

Ministry of Health
Drugs and Devices Division

Application and Consent for the Inherited Metabolic Diseases (IMD) Program

Instructions

For faster approval, submit your IMD application through the SADIE portal. Please visit www.Ontario.ca/SADIE. Alternatively, the completed form and/or any additional information can be faxed to 416-327-8912; or mailed to Delivery and Eligibility Review Branch, 3rd floor, 5700 Yonge Street, Toronto ON M2M 4K5.

You may apply for benefits under the IMD Program if:

- You are, or the person in respect of whom you are submitting an application (the "Patient") is, an Ontario resident with an Ontario health card (see Section 1 of form);
- The Patient has been diagnosed with a metabolic disorder in respect of which certain products are funded under the IMD Program ("IMD Program Benefits") (see Section 4 of form);
- The Patient is being treated by a physician at Children's Hospital of Eastern Ontario, Hospital for Sick Children, Kingston Health Sciences Centre, London Health Sciences Centre, McMaster Children's Hospital, or the University Health Network (see Section 2 of form); and
- The Patient does not have private insurance or employer-sponsored benefits that provide coverage for the IMD Program Benefits that treat their metabolic disorder (access What is covered by the IMD Program).

Confidential when completed.

Fields marked with an asterisk (*) are mandatory.

Section 1. Patient Information

Last Name	First Name	Middle Initial

Health Number	Version	Date of Birth (yyyy/mm/dd)

Sex

☐Male ☐Female ☐Prefer not to answer ☐Other (Specify)

Mailing Address

Unit/Apartment Number	Street Number	Street Name

City/Town	Province	Postal Code	Telephone Number
	ON		

Section 2. Treating Physician Information

Last Name	First Name	Middle Initial	CPSO Number

Specialty or Department	Institution

Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code
	ON	

Telephone Number	Fax Number	Email Address

Section 3. Dietitian Information

Last Name	First Name	Middle Initial

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Institution

Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code
	ON	

Telephone Number	Fax Number	Email Address

Section 4 – Patient Diagnosis

Patient Diagnosis (from approved list)	Date of Diagnosis (yyyy/mm/dd)

Section 5. Physician Signature (if different than the Treating Physician named in Section 2, please provide address and contact information of the physician completing this application)

Physician Signature*	Print Name	CPSO Number	Date (yyyy/mm/dd)

Completed the following if different than the Treating Physician

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code
	ON	

Telephone Number	Fax Number	Email Address

Section 6. For Ministry Use Only

Ministry Approval of Registration	Date (yyyy/mm/dd)

Notes

Declaration

By signing this IMD Program Application and Consent form ("Application"), I confirm that:

- The Patient is applying to receive IMD Program Benefits;
- The Patient does not have private insurance or employer-sponsored benefits that provide coverage for the IMD Program Benefits sought by the Patient;
- The information provided in this Application is true, accurate and complete to the best of my knowledge;
- I understand that I must immediately notify the Ministry in writing of any changes to the information I have provided in this Application, including any relevant changes in respect of the Patient's coverage for Program Benefits under a private plan;
- I consent to the Ministry's collection of the Patient's personal health information contained in this Application for the purpose of administering the IMD Program;
- I consent to the Ministry's collection of the Patient's personal health information from any other source for the purposes of verifying the information in this Application and administering the IMD Program;
- I understand that the Ministry may use and disclose the Patient's personal health information provided in this Application or obtained from other sources for the purpose of verifying the Patient's eligibility, reimbursing claims for payment from service providers, and administering the IMD Program; and
- I understand that, from time to time, the Ministry may effect changes to the IMD Program including, without limitation, eligibility requirements and Program Benefits.

I am either the Patient or the Patient's Substitute Decision-Maker who has authority to submit the Application and consent on behalf of the Patient.

Notice of Collection

This information is collected under the authority of the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3 Sched. A (PHIPA). This information will be used and disclosed to administer the IMD Program. It may also be used and disclosed in accordance with PHIPA, as set out in the Ministry of Health "Statement of Information Practices", which may be accessed at: https://www.ontario.ca/page/statement-information-practices-ministry-health-and-ministry-long-term-care

For more information, write to the Director, Delivery and Eligibility Review Branch, Ministry of Health, at 5700 Yonge Street, 3rd Floor, Toronto ON M2K 4K5, or call 1-866-811-9893. In Toronto, call 416-327-8109.

Signature of Patient or their Substitute Decision-Maker	Date (yyyy/mm/dd)

If the signature above is that of the Patient's Substitute Decision-Maker, and not the Patient, please print the Substitute Decision-Maker's information below, and attach supporting documents, as appropriate:

Last Name	First Name	Identity of Signatory* (see below)

* Categories of Substitute Decision-Maker:

1. Guardian of the Person (attach supporting documentation)
2. Attorney for Personal Care (attach supporting documentation)
3. Representative appointed by Consent and Capacity Board (attach supporting documentation)
4. Spouse/Partner
5. Parent
6. Other relative (specify)