Ontario

Ministry of Health

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5
Tel: 416-327-8804
Toll-Free: 1-800-268-6021
TTY: 416-327-4282
TTY: 1-800-387-5559

Application for Breast Prosthesis Grant

BP1

Section 1 – Applicant's Biographical Information

Last Name	First Name	Middle Initial

Health Number (10 digits)	Version	Date of Birth (yyyy/mm/dd)

Name of Long-Term Care Home (LTCH) (if applicable)

Address

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code

Home Telephone Number	Business Telephone Number ext.

Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If yes, please check one
- ☐ Ontario Works Program (OWP)
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Breast Prosthesis(es) from
- Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No
- Veterans Affairs Canada (VAC) – Group A ☐ Yes ☐ No

Section 2 – Devices and Eligibility

Type of External Silicone Breast Prosthesis(es) Purchased

Left	Date Purchased (yyyy/mm/dd)	Purchase Cost	Right	Date Purchased (yyyy/mm/dd)	Purchase Cost
☐ Full			☐ Full		
☐ Partial			☐ Partial		

Reason for Application (check one reason per side as appropriate)

First access for Breast Prosthesis(es) ☐ Left ☐ Right

Replacement of previously ADP funded Breast Prosthesis(es) due to
- Change in body size/shape ☐ Left ☐ Right
- Change in medical condition ☐ Left ☐ Right
- Normal wear (and no longer under warranty) ☐ Left ☐ Right

Confirmation of Applicant's Medical Eligibility (check as appropriate)

I was born with a breast deformity ☐ Left ☐ Right

I have undergone a mastectomy or lumpectomy

Left	Date of Surgery (yyyy/mm)	Right	Date of Surgery (yyyy/mm)
☐ Lumpectomy		☐ Lumpectomy	
☐ Mastectomy		☐ Mastectomy	

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Applicant's Last Name	First Name	Health Number (10 digits)	Version

Section 3 – Applicant's Consent & Signature

Note: This section of the form may be signed only by the applicant or his or her agent

I consent to the Ministry of Health (the Ministry) collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive benefits under the Ministry's Assistive Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and Insurance Board (WSIB) collecting, using and disclosing personal information about me, including the information on this form and information related to my entitlement to health care benefits under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and verifying my eligibility to receive benefits under the Program and WSIA.

The Ministry and WSIB will limit the information that they exchange about me to only that information that is necessary for the purpose above.

The Ministry will only use and disclose my personal health information in accordance with the *Personal Health Information Protection Act,* 2004, and the Ministry's "Statement of Information Practices" which is accessible at www.health.gov.on.ca**.** In addition, the WSIB will collect, use and disclose personal information about me from the Ministry for the purpose of administering and enforcing the WSIA**.**

I understand that if I choose to withhold or withdraw my consent to the collection, use and disclosure of this information by the Ministry or WSIB, I may be denied coverage under the Program.

For more information on the Ministry's Information Practices, or the collection, use or disclosure of the personal information on this form, call 1-800-268-6021/416-327-8804 or TTY: 416-327-4282 or write to the Program Manager, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5.

I have read the Applicant Information Sheet, understand the rules of eligibility for ADP and am eligible for the equipment specified.
I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit.

Signature	☐ Applicant ☐ Agent	Date (yyyy/mm/dd)

If the above signature is not that of the applicant, specify relationship to applicant and fill out contact information

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Public Trustee
- ☐ Power of Attorney

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code

Home Telephone Number	Business Telephone Number ext.

Note: Attachments will not be considered by the Assistive Devices Program

It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding.