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 Funding Communication Aids

Fields marked with an asterisk (*) are mandatory.

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 *
	ON	

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 Communication Aids from:

Workplace Safety & Insurance Board (WSIB) ☐Yes ☐No

Veterans Affairs Canada (VAC) – Group A ☐Yes ☐No

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Applicant's Last Name	First Name	Health Number (10	Versior

Section 2 – Devices and Eligibility

Diagnosis: (to be completed by Physician/Nurse Practitioner)

Primary Diagnosis	Secondary Diagnosis

Devices/Supplies Required: (check as appropriate) (to be completed by Authorizer)

Face-to-Face Communication Aids

Electrolarynx		☐Purchase	Carrying Case for Simple SGD/VOCA		☐Purchase
Voice Amplifier		☐Purchase	Communication Display Board		☐Purchase
Voice Restoration & Speaking Valves		☐Purchase	Speech Generating Device (SGD/VOCA)**	☐Lease	☐Purchase
Quick Messaging Device		☐Purchase	Keyguard for SGD/VOCA	☐Lease	☐Purchase
Simple SGD/VOCA**		☐Purchase	Carrying Case for SGD/VOCA	☐Lease	☐Purchase
Display Making Software		☐Purchase	SGD/VOCA Software**	☐Lease	☐Purchase
Keyguard for Simple SGD/VOCA		☐Purchase	SGD/VOCA Access Hardware**	☐Lease	☐Purchase

Writing Aids

Simple Writing Aid		☐Purchase	Carrying Case for Writing Aid	☐Lease	☐Purchase
Keyguard for Simple Writing Aid		☐Purchase	Adaptive Word Processing Software**	☐Lease	☐Purchase
Carrying Case for Simple Writing Aid		☐Purchase	Writing Aid Access Software - Keyboard**	☐Lease	☐Purchase
Stationary Computer System	☐Lease	☐Purchase	Writing Aid Access Software - Mouse**	☐Lease	☐Purchase
Portable Computer System	☐Lease	☐Purchase	Writing Aid Access Software - Kb & Mouse**	☐Lease	☐Purchase
Keyguard for Writing Aids	☐Lease	☐Purchase	Writing Aid Access Hardware**	☐Lease	☐Purchase

Integrated Systems

Integrated Systems**	☐Lease	☐Purchase

Other

Setup Fee for SGD/VOCA and Writing Aid		☐Purchase
Shipping and Handling Fee	☐Lease	☐Purchase

Accessories

Simple Non-Computerized Pointer		☐Purchase	Non-Computerized Pointer (Clinics)	☐Lease	☐Purchase
Simple Switch		☐Purchase	Switches**	☐Lease	☐Purchase
Simple Mounting System - Device		☐Purchase	Mounting System for Device	☐Lease	☐Purchase
Simple Mounting System - Access H/W		☐Purchase	Mounting System for Access Hardware	☐Lease	☐Purchase
Keyboard**	☐Lease	☐Purchase	Wheelchair Accessories for Comm Aids	☐Lease	☐Purchase
Mouse Alternative**	☐Lease	☐Purchase	Wheelchair Control Unit for Comm Aids		☐Purchase

☐Select this box if above 'purchases' represent lease buyouts (to be submitted on separate claim from other purchases or leases)

Make and Model Description of Devices Authorized: (required for those devices marked with **) (to be completed by Authorizer)

Reason for Application: (check one) (to be completed by Authorizer)

☐ First access to ADP for Communication Aids

☐ Another type of device required in addition to Previously ADP Funded Communication Aid(s)

☐ Replacement of Previously ADP Funded Communication Aid(s)

Replacement Communication Aid(s) Required Due To: (check one if required) (to be completed by Authorizer)

☐Change in medical condition

☐Physical Growth / Atrophy

☐Normal wear and applicant confirms that it is no longer warranty

Applicant's Last Name	First Name	Health Number (10	Versior

Section 3 – Applicant's Consent and 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 the 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 of the personal health information on this form, call 1-800-268-6021 or 416-327-8804 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.

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

If the above signature is not that of the applicant, specify relationship and complete contact information below

☐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.

Applicant's Last Name	First Name	Health Number (10	Versior

Section 4 – Signatures

Physician/Nurse Practitioner's Signature (if applicable)

I hereby certify that the applicant has a chronic physical disability requiring the regular use of the prescribed Communication Aid(s).

☐Physician ☐Nurse Practitioner

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name
Business Telephone Number * ext.	Ontario Health Insurance Billing No (6 digits)
	Date Signed (yyyy/mm/dd)

Authorizer`s Signature and Confirmation of Applicant's Eligibility

I hereby certify that I have personally assessed the applicant named on this form in person. Based on my assessment of this individual's medical requirements, I have confirmed his/her eligibility for funding assistance in accordance with ADP funding guidelines. I confirm that the client may not use the device solely for educational, vocation and recreational purposes, for computer aided learning or for therapeutic purposes. I have advised the applicant or his/her agent that he/she may purchase the ADP approved equipment from the ADP Registered Vendor of their choice, and have provided a list of ADP Registered Vendors in the applicant's community for their use.

Authorizer's Last Name	Authorizer`s First Name
Business Telephone Number * ext.	ADP Authorizer Registration Number
	Assessment Date (yyyy/mm/dd)

Clinic (if applicable)

Clinic Name	ADP Clinic Number	Business Telephone Number * ext.

Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number
Vendor Representative's Last Name	Vendor Representative's First Name
Position Title	Business Telephone Number * ext.
Vendor Location	
	Date (yyyy/mm/dd)

☐Client is pursuing purchase via a non-registered vendor

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.