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 Hearing Devices

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 * ON	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 Hearing Devices from

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

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

Section 2 – Devices and Eligibility

Device Selection (to be completed by Authorizer)

Hearing Aid(s)

Behind the Ear	☐Left	☐Right	Canal Aid	☐Left	☐Right
In the Ear	☐Left	☐Right	Completely in the Canal	☐Left	☐Right

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

Other Hearing Devices

Cochlear Implant Replacement Speech Processor ☐Left ☐Right

Date of Surgery (yyyy/mm) (Left) Date of Surgery (yyyy/mm) (Right)

Bone Anchored Hearing Aid Replacement Sound Processor with abutment ☐Left ☐Right

Bone Anchored Hearing Aid Replacement Sound Processor without abutment ☐Left ☐Right

Replacement Abutment Only ☐Left ☐Right

Date of Surgery (yyyy/mm) (Left) Date of Surgery (yyyy/mm) (Right)

☐FM System

☐Teletypewriter (TTY)

☐Flashing/Signalling Device

Reason for Application (check one or more as appropriate)

☐First access for Hearing Devices

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

☐Replacement of Previously ADP Funded Hearing Device

Replacement Required Due To: (check one or more if applicable)

☐Change in medical condition. Previously funded equipment no longer meeting client's needs.
Hearing Aids Only: minimum 20db loss across 3 speech frequencies

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

☐**Vendor quote and/or copies of repair bills attached (other attachments will not be considered)**

Confirmation of Applicant's Eligibility (to be completed by Authorizer)

Hearing Aids (answer required for question 1)

1. There is documented evidence of the need for the hearing aid to meet applicant's basic daily listening needs based on established clinical assessment tools.	☐Yes	☐No	☐N/A

FM Systems (answer required for questions 2 - 4)

2. There is documented evidence of the ability of applicant/caregiver to use an FM System effectively to meet the applicant's basic daily listening needs and the benefits and limitations of FM technology have been explained to the applicant/caregiver.	☐Yes	☐No	☐N/A
3. At the time the FM system was dispensed, the ADP Registered Vendor has obtained the applicant/agent's signature confirming that: • education was provided to the applicant/caregiver on the use, care/maintenance and trouble-shooting of the device; and • applicant / agent was provided details regarding the minimum 30 day trial period and a minimum 1 year warranty.	☐Yes	☐No	☐N/A
4. The ADP Registered Authorizer has documented confirmation prior to the end of the trial period that the FM System meets the applicant's basic daily listening needs and that the applicant is using the system as authorized.	☐Yes	☐No	☐N/A

TTY or Flashing/Signalling Device (answer required for questions 5 - 6)

5. The applicant has a hearing loss severe enough to impede normal use of a telephone even with the use of a hearing aid and a voice amplified telephone, and requires the long-term use of a TTY and accompanying flashing-signalling device if required.	☐Yes	☐No	☐N/A
6. The applicant has a speech impairment severe enough to impede normal use of the telephone even with the use of an augmentative communication aid and requires the TTY on a long-term basis.	☐Yes	☐No	☐N/A

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

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 (refer to definitions in the Policies and Procedures Manual for the Assistive Devices Program)

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 https://www.ontario.ca/page/statement-information-practices-ministry-health-and-ministry-long-term-care**.** 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.

If I am signing this form as the Agent of the Applicant, I confirm that I am the Applicant's substitute decision maker as defined in the *Personal Health Information Protection Act, 2004* and am authorized to consent to the collection, use and disclosure of the Applicant's personal health information.

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.

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

If the above signature is not that of the applicant, specify relationship and complete 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.

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

Section 4 – Signatures

Authorizer's Signature and Confirmation of Applicant's Eligibility

I hereby certify that I have personally assessed in person the Applicant named on this form. Based on my assessment of the applicant's medical requirements, I have confirmed their eligibility for funding assistance in accordance with all ADP funding policies. I have advised the Applicant or their Agent that the Applicant 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)

Vendor Information

I hereby certify that the Applicant named above or their Agent has read and understood the Attestation Sheet – Your Rights and Important Information About Getting a Hearing Aid in Ontario. * ☐Yes ☐No ☐N/A

I hereby certify that the Applicant named above has received the items as authorized.

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) / Invoice Number

Equipment Specifications (to be completed by Vendor)

Device Placement			ADP Device Code	Make and Model Description	Serial Number	ADP Portion ($)	Client Portion ($)
Left	Right	N/A					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

Proof of Delivery (to be completed by Applicant)

I confirm that I have received the device(s) as specified above. I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

	Date (yyyy/mm/dd)

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

Note: Attach vendor quote and/or repair bills if required (see Section 2)

Other 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.