Ontario

Ministry of Health

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

Application for Funding:

Home Oxygen Therapy

To be used for all applications for Home Oxygen Therapy funding.

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 Home Oxygen benefits from

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

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

I am a resident of a Long-Term Care Home (LTCH) ☐Yes ☐No

I reside in an acute or a chronic care hospital ☐Yes ☐No

I am receiving professional services through the Home and Community Care Support Services (HCCSS) ☐Yes ☐No

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

Section 2 – Devices and Eligibility

Applicant is accessing funding for the first time **or** there is a gap in funding greater than 90 days **or** previous therapy was discontinued by the physician or nurse practitioner. ☐Yes ☐No

Funding Program Requested (check one) (to be completed by Vendor) *

☐Short Term Oxygen Therapy

☐Long Term Oxygen Therapy for Resting Hypoxemia

☐Long Term Oxygen Therapy for Children

☐Long Term Oxygen Therapy for Exertional Hypoxemia

☐Palliative Care

Delivery System Requested (to be completed by Vendor) *

☐System **Or** Small Cylinders # required ☐Low-flow required

Large Cylinders # required ☐Low-flow required

Date of System/Cylinder Installation (yyyy/mm/dd)

Confirmation of Applicant's Eligibility for Home Oxygen Funding (to be completed by Physician/Nurse Practitioner) *

Diagnoses (check all that apply)

Obstructive Lung Disease

☐chronic bronchitis ☐emphysema ☐cystic fibrosis

☐bronchiectasis ☐bronchopulmonary dysplasia ☐chronic obstructive pulmonary disease (COPD)

Restrictive Lung Disease

☐interstitial lung disease ☐kyphoscoliosis ☐neuromuscular disease (specify)

Sleep Disorder Breathing

☐OSAS (Obstructive Sleep Apnea) ☐CSAS (Central Sleep Apnea)

Other

☐palliative (specify)

☐other diagnosis (specify)

Complications

☐cor pulmonale ☐pulmonary hypertension ☐secondary polycythemia Indicate hematocrit %

Test Results

A. Must be completed for all funding programs indicated except Palliative Care (to be completed by Physician/Nurse Practitioner or Regulated Health Professional)

Print-outs of oximetry test results, signed and dated, must accompany this form. ☐Attached – oximetry test results

ABGs

PaO2 (mmHg)	Date (yyyy/mm/dd)	☐ABGs could not be taken due to medical risk

Oximetry (SpO2)

Rest	Exertion	Sleep
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)	Date (yyyy/mm/dd)

Did physician/nurse practitioner personally perform the oximetry test? ☐Yes ☐No

Note: If No, signature section for Health Professional must be filled.

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

B. Short Term Oxygen Therapy (must be completed if Short Term Oxygen Therapy is indicated)
(to be completed by Physician/Nurse Practitioner or Registered Respiratory Therapist)

Note: If this section is completed by a Registered Respiratory Therapist, only the Registered Respiratory Therapist employed by the acute care hospital and who assessed the above applicant's need for home oxygen therapy can answer the three questions below.

Applicant is an inpatient at a long-term care home and requires home oxygen therapy to prevent an emergency room visit. ☐Yes ☐No

Applicant was an inpatient in an acute care hospital and required home oxygen therapy to be discharged. ☐Yes ☐No

Applicant was in the emergency department and required home oxygen therapy to be discharged. ☐Yes ☐No

C. Long Term Oxygen Therapy for Exertional Hypoxemia: Independent Exercise Assessment (IEA)
(must be completed if Exertional Hypoxemia is indicated)

To be completed by Regulated Health Professional or designated Pulmonary Function Tech

Date of Test (yyyy/mm/dd)

Is this a single blind study? ☐Yes ☐No

Results on Compressed Air (time walked must be indicated)	**Results on Oxygen Therapy** (time walked must be indicated)
SpO_2 at end of walk test	Total time walked minutes
Total time walked minutes	BORG score (0 - 10)
BORG score (0 - 10)	

Where was IEA performed? ☐Hospital ☐Independent Health Facility (IHF)

IHF Registration Number (not required for hospital)

Name of hospital or IHF

Test result confirmation (to be completed by the Respirologist/Internist reviewing the IEA)

Note: If the physician (in Section 4) is a Respirologist/Internist, this section does not need to be signed.

I hereby certify that this test has been conducted in accordance with the guidelines provided by the Assistive Devices Program at an Independent Health Facility (IHF) or at a hospital, and by an approved tester.

IHF/Hospital Physician's Last Name	IHF/Hospital Physician's First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (4 to 6 digits)
	Date Signed (yyyy/mm/dd)

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 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.

If the applicant or any other resident of the applicant's household smokes, the applicant on behalf of their heirs and assigns, releases His Majesty the King in the right of the Province of Ontario as represented by the Minister of Health and Long-Term Care, his employees and agents from any responsibility for any damages or losses that may occur as a result of smoking and concurrent use of oxygen.

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	Versior

Section 4 – Signatures

Physician/Nurse Practitioner Signature or Registered Respiratory Therapist Signature *

Note: This section only needs to be completed by the Physician/Nurse Practitioner or the Registered Respiratory Therapist

I hereby certify that the applicant has appropriately tried other treatment measures without success. Oxygen therapy and oxygen equipment as prescribed is medically indicated and is reasonable and necessary for the treatment of this patient.

☐Physician ☐Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number * ext.	Ontario Health Insurance Billing Number (4 to 6 digits)
	Date Signed (yyyy/mm/dd)

Or

Registered Respiratory Therapist

Registered Respiratory Therapist Last Name	Registered Respiratory Therapist First Name
Business Telephone Number * ext.	College Registration/Certificate Number

I confirm that when I assessed the above applicant:

- I was employed at an acute/chronic care hospital or in the community ☐Yes ☐No
- I was not employed by a Vendor of Record for Home Oxygen Services ☐Yes ☐No

	Date Signed (yyyy/mm/dd)

Regulated Health Professional Signature (section must be filled if Physician/Nurse Practitioner did not complete the oximetry test)

I confirm that I performed a pulse oximetry test on the applicant on the dates noted above. This test was conducted to the best of my ability and the results submitted are listed in Section 2 above.

Last Name	First Name
Profession	
Business Telephone Number * ext.	College Registration/Certificate Number
	Date Signed (yyyy/mm/dd)

The Ministry of Health reserves the right to confirm that the Health Professional indicated above is a member in good standing with the appropriate professional college.

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

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

Position Title	Business Telephone Number * ext.

Vendor Location

	Date Signed (yyyy/mm/dd)

Provide supporting documentation if required. 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.