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 Insulin Pumps and Supplies for Children

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 Insulin Pumps or Supplies 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 (to be completed by Physician/Nurse Practitioner)

Devices/Supplies Required (check all that apply)

☐Insulin Pump ☐Supplies for ADP listed Insulin Pump

Reason for Application (only required for Insulin Pump funding request)

☐First access for Insulin Pump & Supplies category ☐Replacement of Previously ADP Funded Device(s)

Replacement Pump Required Due To (check as appropriate)

☐Change in applicant's medical status

☐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: answers required to all the statements

To be completed by an Endocrinologist or another Specialist Physician or Nurse Practitioner who is associated with one of the paediatric diabetes programs that are part of the Network of Ontario Paediatric Diabetes Programs (NOPDP)

Please confirm that the following Eligibility Criteria have been met:

1. Applicant has Type1 diabetes	☐Yes	☐No
2. Blood glucose monitoring before each meal and before bedtime	☐Yes	☐No
3. Ongoing monitoring of blood glucose test results	☐Yes	☐No
4. Appropriate insertion style rotation	☐Yes	☐No
5. Appropriate sick day management with not more than one episode of DKA in the previous six (6) months	☐Yes	☐No
6. Regular attendance at the diabetes clinic (at least 3 times a year)	☐Yes	☐No
7. Completion of an Insulin Pump education program	☐Yes	☐No

Date insulin pump therapy 90 day trial was initiated (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.

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.

Please indicate the payee and authorize by signature below:

☐Payment to Applicant ☐Payment to Agent (provide contact info below)

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

If designated payee or signature above is not that of the applicant, 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 Signature

I certify that the applicant has Type 1 diabetes and has demonstrated a clinical need for insulin pump therapy and has participated in a diabetes education program.

☐Physician ☐Nurse Practitioner

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name
Business Telephone Number * ext.	Ontario Health Insurance Billing No (5 or 6 digits)
	Date Signed (yyyy/mm/dd)

Name of Paediatric Diabetes Education Program

Program Name	ADP Clinic Number	Business Telephone Number * ext.

Vendor Information (for pump only)

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

Vendor Business Name	ADP Vendor Registration

Vendor Representative's Last Name	Vendor Representative's First Name
Position Title	Business Telephone Number * ext.
Vendor Location	

	Date (yyyy/mm/dd)	Vendor Invoice Number

Equipment Specifications (for pump only)

ADP Device Code	Description of Item (Make & Model)	Serial Number
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Proof of Delivery (for pump only)

To be completed and signed by the applicant, parent or agent

I confirm that I have received the insulin pump described in Section 4 and that I agree to participate in a 90 day trial. If at the end of the 90 day trial period, it is determined that I am not a suitable candidate for insulin pump therapy at this time, I agree to return the insulin pump to the vendor indicated in Section 4. On receipt of the returned insulin pump the vendor must credit ADP the full amount of the ADP price in order to ensure that I may reapply at a later date.

	☐Applicant ☐Agent	Date (yyyy/mm/dd)

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.