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 Limb Prostheses

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 Limb Prostheses 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 digits) | Version |
|---|---|---|---|
| | | | |

## Section 2 – Devices and Eligibility

**Diagnosis, Amputation Type, and Surgical Procedure (if applicable) to be provided by Physician**

**Diagnosis**

**Amputation Type**

☐Congenital Condition ☐Acquired Amputation

**Surgical Procedure (if applicable)**

Type of Surgery

Date of Surgery (yyyy/mm)

**Device Selection and Reason for Application (to be completed by Authorizer)**

**List of Valid Application Reasons** (application reason number to be provided next to device selection in below):

1. Initial Preparatory or Definitive Device (for that side and amputation level)
2. Additional Items for device(s) currently in use
3. Modifications or Adjustments
4. Replacement – Growth
5. Replacement – Atrophy
6. Replacement – Normal Wear
7. Replacement – Change in Medical Condition

**Conventional –Lower Extremity**

**Preparatory Sockets Non-Laminated**

| | | | | | |
|---|---|---|---|---|---|
| Ankle Disarticulation | ☐Left | ☐Right | Trans-Femoral | ☐Left | ☐Right |
| Trans-Tibial | ☐Left | ☐Right | Hip Disarticulation | ☐Left | ☐Right |
| Knee Disarticulation | ☐Left | ☐Right | Trans-Pelvis | ☐Left | ☐Right |

**Preparatory Sockets Laminated**

| | | | | | |
|---|---|---|---|---|---|
| Ankle Disarticulation | ☐Left | ☐Right | Trans-Femoral | ☐Left | ☐Right |
| Trans-Tibial | ☐Left | ☐Right | Hip Disarticulation | ☐Left | ☐Right |
| Van Nes Procedure | ☐Left | ☐Right | Trans-Pelvis | ☐Left | ☐Right |
| Knee Disarticulation | ☐Left | ☐Right | | | |

**Preparatory Socket – Additions (Laminated or Non-Laminated)** ☐Left ☐Right

**Definitive Sockets**

| | | | | | |
|---|---|---|---|---|---|
| Partial Foot | ☐Left | ☐Right | Hip Disarticulation | ☐Left | ☐Right |
| Ankle Disarticulation | ☐Left | ☐Right | Trans-Pelvis | ☐Left | ☐Right |
| Trans-Tibial | ☐Left | ☐Right | Components – Lower Extremity | ☐Left | ☐Right |
| Van Nes Procedure | ☐Left | ☐Right | Modifications – Price Listed | ☐Left | ☐Right |
| Knee Disarticulation | ☐Left | ☐Right | Modifications – Price Not Listed (complete Modification section) | ☐Left | ☐Right |
| Trans-Femoral | ☐Left | ☐Right | | | |

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

**Test Sockets**

| | | | |
|---|---|---|---|
| Ankle Disarticulation | ☐ | Trans-Femoral | ☐ |
| Trans-Tibial | ☐ | Hip Disarticulation | ☐ |
| Knee Disarticulation | ☐ | Trans-Pelvis | ☐ |

**Supplements/Suspensions**

| | | | |
|---|---|---|---|
| Partial Foot | ☐ | Knee Disarticulation | ☐ |
| Ankle Disarticulation | ☐ | Trans-Femoral | ☐ |
| Trans-Tibial | ☐ | Hip Disarticulation | ☐ |
| Van Nes Procedure | ☐ | Trans-Pelvis | ☐ |

## Conventional –Upper Extremity

**Definitive Sockets**

| | | | | | |
|---|---|---|---|---|---|
| Partial Hand | ☐ Left | ☐ Right | Shoulder Disarticulation | ☐ Left | ☐ Right |
| Wrist Disarticulation | ☐ Left | ☐ Right | Control Systems | ☐ Left | ☐ Right |
| Trans-Radial | ☐ Left | ☐ Right | Components – Upper Extremity | ☐ Left | ☐ Right |
| Elbow Disarticulation | ☐ Left | ☐ Right | Modifications – Price Listed | ☐ Left | ☐ Right |
| Trans-Humeral | ☐ Left | ☐ Right | Modifications – Price Not Listed (complete Modification section) | ☐ Left | ☐ Right |
| Forequarter | ☐ Left | ☐ Right | | | |

**Test Sockets**

| | | | |
|---|---|---|---|
| Wrist Disarticulation | ☐ | Trans-Humeral | ☐ |
| Trans-Radial | ☐ | Shoulder Disarticulation | ☐ |
| Elbow Disarticulation | ☐ | Forequarter | ☐ |

**Supplements/Suspensions**

| | | | |
|---|---|---|---|
| Wrist Disarticulation | ☐ | Trans-Humeral | ☐ |
| Trans-Radial | ☐ | Shoulder Disarticulation | ☐ |
| Elbow Disarticulation | ☐ | Forequarter | ☐ |

## Externally Powered – Upper Extremity

**Definitive Prostheses**

| | | | | | |
|---|---|---|---|---|---|
| Wrist Disarticulation | ☐ Left | ☐ Right | Trans-Humeral | ☐ Left | ☐ Right |
| Trans-Radial | ☐ Left | ☐ Right | Shoulder Disarticulation | ☐ Left | ☐ Right |
| Elbow Disarticulation | ☐ Left | ☐ Right | Forequarter | ☐ Left | ☐ Right |

**Replacement Sockets/Components**

| | | | | | |
|---|---|---|---|---|---|
| Wrist Disarticulation | ☐ Left | ☐ Right | Shoulder Disarticulation | ☐ Left | ☐ Right |
| Trans-Radial | ☐ Left | ☐ Right | Forequarter | ☐ Left | ☐ Right |
| Elbow Disarticulation | ☐ Left | ☐ Right | Electric Hand | ☐ Left | ☐ Right |
| Trans-Humeral | ☐ Left | ☐ Right | Electric Elbow | ☐ Left | ☐ Right |

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

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

**Conventional Limb Prostheses**

1. Applicant requires a conventional limb prosthesis as a substitute for a partially or totally absent arm or leg. ☐Yes ☐No ☐N/A

**Externally Powered Upper Limb Prostheses**

2. Applicant requires an externally powered upper limb prosthesis as a substitute for a partially or totally absent upper limb. ☐Yes ☐No ☐N/A

**Modification or Adjustment Required: (complete for Modifications that have Price Not Listed) (to be completed by Authorizer)**

Device being modified

Description of modification required: (**Note**: Cost of Modification must be a minimum of $100 and cannot exceed 30% of the replacement cost)

| Technical Time Hours | Clinical Time Hours | Materials Cost: $ | Total Cost: $ |
|---|---|---|---|
| | | | |

**Special Approval Requested: (complete if applicable) (to be completed by Authorizer)**

☐Applicant requires a device which is a hybrid combination of both orthotic and prosthetic components

Device required

| 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**

The Ministry of Health (the Ministry) collection of the personal health information on or attached to this form is necessary for the purpose of assessing and verifying eligibility for the Assistive Devices Program, and for all other purposes related to the proper administration of that Program.

This information may be used or disclosed in accordance with the *Personal Health Information Protection Act*, 2004, as set out in the Ministry's "Statement of Information Practices" which is accessible at: www.health.gov.on.ca**.**

Applicants may withhold their consent to the collection of this information; however, doing so will interfere with their coverage under the Assistive Devices 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 consent to the collection and disclosure of medical and non-medical information for the purpose of assessing and verifying eligibility for the Assistive Devices Program and for all other purposes related to the proper administration of that Program.

I consent to the collection and disclosure of medical and non-medical information by the Assistive Devices Program (ADP) to the Workplace Safety & Insurance Board (WSIB) and to Veterans Affairs Canada (VAC), and by the WSIB and VAC to the ADP, to determine my eligibility to receive assistance from the ADP.

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 digits) | Version |
|---|---|---|---|
| | | | |

## Section 4 – Signatures

**Physician's Signature**

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic physical disability requiring the regular use of the prescribed prosthetic items(s).

| Physician's Last Name | Physician'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 in person and determined that the applicant meets ADP eligibility criteria. I have also authorized the equipment described on this form.

| Authorizer's Last Name | Authorizer's First Name |
|---|---|
| | |

| Business Telephone Number * ext. | ADP Authorizer Registration Number |
|---|---|
| | |

| | Assessment Date (yyyy/mm/dd) |
|---|---|
| | |

**Rehabilitation Assessor's Signature (if applicable)**

I certify that I have conducted a rehabilitation assessment of the applicant. I confirm that the applicant requires the use of an artificial limb for a range of daily activities within the ADP eligibility guidelines.

| Rehabilitation Assessor's Last Name | Rehabilitation Assessor'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) |
|---|---|
| | |

**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.**