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 Maxillofacial Extraoral 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 *	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 Maxillofacial Extraoral Prostheses from:

- Workplace Safety & Insurance Board (WSIB) ☐Yes ☐No
- Veterans Affairs Canada (VAC) ☐Yes ☐No

Section 2 – Devices and Eligibility (to be completed by Authorizer)

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

Devices Required (check one or more as appropriate)

Auricular prosthesis

New ☐Left ☐Right

Repeat ☐Left ☐Right

Orbital prosthesis

New ☐Left ☐Right

Repeat ☐Left ☐Right

Orbitomaxillary prosthesis

New ☐Left ☐Right

Repeat ☐Left ☐Right

Nasal prosthesis

New ☐

Repeat ☐

Nasomaxillary prosthesis

New ☐

Repeat ☐

Reason for Application (check one)

☐First access to ADP for Maxillofacial Extraoral Prostheses

☐Another type of device required in addition to Previously ADP Funded Prosthesis(es)

☐Replacement of a Previously ADP Funded Prosthesis(es)

Replacement Prosthesis Required Due To (check as appropriate)

☐Change in medical condition

☐Physical growth/atrophy

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

Confirmation of Applicant's Eligibility:

Applicant requires a prosthesis as a substitute for a partially or totally absent facial part ☐Yes ☐No

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

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.

	☐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 Maxillofacial Extraoral Prosthesis(es).

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 and advised the applicant or his/her agent that he/she may purchase the ADP Approved Prosthesis(es) from any 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 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.