Ontario

Ministry of Health

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Telephone: 416-327-8804
TTY: 416-327-4282

Toll-free: 1-800-268-6021
TTY: 1-800-387-5559

Application for Funding Orthotic 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 Orthotic Devices from

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

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

Section 2 – Devices and Eligibility

Applicant's presenting medical condition (to be completed by Physician/Nurse Practitioner OR Rehabilitation Assessor)

Device(s) Required: (to be completed by Authorizer)

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

List of Classes (Class number to be entered next to device selection below)

- Class 1A
- Class 1B
- Class 2
- Class 3

Cranial	**Class**	**Price** (Class 3)
☐Cranial		$

Spinal	**Class**	**Price** (Class 3)
☐Scoliosis		$
☐Lumbo-Sacral		$
☐Conventional Lumbo-Sacral		$
☐ Thoraco-Lumbo-Sacral		$
☐Conventional Thoraco-Lumbo-Sacral		$
☐Cervical Thoraco-Lumbo-Sacral		$
☐Cervical		$
☐Cervical Thoracic		$

Lower Extremity	**Left**	**Class**	**Price** (Class 3)	**Right**	**Class**	**Price** (Class 3)
☐Non-Articulated Ankle-Foot	☐		$	☐		$
☐Articulated Ankle-Foot	☐		$	☐		$
☐Energy Storing Ankle-Foot	☐		$	☐		$
☐Charcot Restraint Ankle-Foot	☐		$	☐		$
☐Patella Tendon Bearing Ankle-Foot	☐		$	☐		$
☐Supra Malleolar Ankle-Foot	☐		$	☐		$
☐Knee	☐		$	☐		$
☐Knee-Ankle-Foot	☐		$	☐		$
☐Hip-Knee-Ankle-Foot	☐		$	☐		$
☐Hip	☐		$	☐		$
☐Hybrid (Orthotic Portion Only)	☐		$	☐		$
☐Abduction Boots and Bars						

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Upper Extremity	**Left**	**Class**	**Price** (Class 3)	**Right**	**Class**	**Price** (Class 3)
☐Short Opponens	☐		$	☐		$
☐Wrist-Hand-Finger	☐		$	☐		$
☐Wrist-Hand-Finger – Dynamic	☐		$	☐		$
☐Wrist-Hand – Leather	☐		$	☐		$
☐Wrist-Hand	☐		$	☐		$
☐Wrist-Hand – Dynamic	☐		$	☐		$
☐Elbow-Wrist-Hand-Finger	☐		$	☐		$
☐Elbow-Wrist-Hand-Finger – Dynamic	☐		$	☐		$
☐Elbow	☐		$	☐		$
☐Elbow – Dynamic	☐		$	☐		$
☐Shoulder Elbow	☐		$	☐		$
☐Shoulder-Elbow-Wrist-Hand-Finger	☐		$	☐		$
☐Hybrid (Orthotic Portion Only)	☐		$	☐		$

Listed Components/Additions

Please describe all base devices to which listed components/additions are being added, as well as the quantity of listed components/additions being added to each base device. Class 1A and 1B base devices are not eligible for listed components/additions. When fabricating a new Class 3 base device, or when modifying a Class 2 or Class 3 base device, the cost of any listed components/additions used should be bundled into the overall Class 3 or Modification price.

☐Peripheral Control Device

Device 1

Device 2

Device 3

☐Composite Addition

Device 1

Device 2

Device 3

Reason for Application: **(to be completed by Authorizer)**

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Check **one**:

☐First access to ADP for Orthotic Devices

☐Replacement of Previously ADP Funded Orthotic Device(s)

☐Modification to Orthotic Device(s) (complete Modifications section below)

Replacement and/or Modification Required Due To: (to be completed by Authorizer)

Check as applicable:

☐Change in medical condition

☐Physical Growth/Atrophy

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

Modifications

☐Modification

Modification 1 – Required: (complete if applicable) (to be completed by Vendor)

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)

Total Cost of Modification: $

Cost to Replace Device: $ (Note: Please quote or estimate what it would cost to replace the device being modified)

Modification 2 – Required: (complete if applicable) (to be completed by Vendor)

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)

Total Cost of Modification: $

Cost to Replace Device: $ (Note: Please quote or estimate what it would cost to replace the device being modified)

Class 2 Attestation: (must be completed for all Class 2 devices) (to be completed by Vendor)

☐I confirm that a Class 2 device is necessary because no available Class 1 device would adequately address the applicant's medical needs.

Class 3 Special Approval Attestation: (must be completed for all Class 3 devices) (to be completed by Vendor)

☐I confirm that a Class 3 device is necessary because neither a Class 1 nor a Class 2 device would adequately address the applicant's medical needs. I will retain a full justification for the Class 3 device, and for its cost.

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

1. Applicant has a long-term physical disability related to their presenting medical condition. ☐Yes ☐No

2. Applicant requires the use of an orthosis on an ongoing daily basis to improve function in a variety of activities of daily living. ☐Yes ☐No

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

Section 3 – Applicant's Consent & 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	Versior

Section 4 – Signatures

Physician/Nurse Practitioner Signature ☐Physician ☐Nurse Practitioner

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name
Business Telephone Number * ext.	Ontario Health Insurance Billing Number (4 to 6 digits)

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 Orthotic Device(s).

Date Signed (yyyy/mm/dd)

OR Rehabilitation Assessor Signature ☐Occupational Therapist ☐Physiotherapist

Rehabilitation Assessor Last Name	Rehabilitation Assessor First Name
Business Telephone Number * ext.	ADP Registration Number

I certify that I have conducted a rehabilitation assessment of the applicant. I confirm that the applicant requires the use of the indicated Orthotic Device(s) for a range of daily activities within the ADP eligibility guidelines.

Assessment Date (yyyy/mm/dd)

Authorizer's Signature and Confirmation of Applicant's Eligibility

Authorizer's Last Name	Authorizer's First Name
Business Telephone Number * ext.	ADP Authorizer Registration Number

I hereby certify that I have personally assessed the applicant in person. Based on my assessment of this individual's medical requirements, I have confirmed his/her eligibility for funding assistance in accordance with all ADP funding guidelines. I have advised the applicant or his/her agent that he/she 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.

Assessment Date (yyyy/mm/dd)

Vendor Information

Vendor Business Name	ADP Vendor Registration Number
Vendor Representative Last Name	Vendor Representative First Name
Position Title	Business Telephone Number * ext.
Vendor Location	

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Date (yyyy/mm/dd)

Note: Attachments will not be considered by the Assistive Devices Program

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It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding. ADP claims are also subject to claim verification and review, as described in the Policies and Procedures Manual for the Assistive Devices Program. The Ministry may take corrective action if any non-compliance with ADP policies is identified, which may include the termination of applicable agreements or recovery of funds.