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
Ostomy Grant

OG1

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 Ostomy Supplies 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 am a patient of an acute or a chronic care hospital ☐Yes ☐No

Section 2 – Type of Permanent Ostomy (to be completed by Physician)

☐Permanent Colostomy	☐Permanent Urostomy
☐Permanent Ileostomy	☐Permanent Ileal Conduit
☐Permanent Fecal Continent Reservoir	☐Permanent Urinary Continent Reservoir
Date of Surgery (yyyy/mm)	Date of Surgery (yyyy/mm)

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Applicant's Last Name	Applicant's 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

The Ministry of Health's (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 grant.

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 and that I am therefore obliged to retain receipts.

Please indicate the payee and authorize by signature below

☐Payment to Applicant ☐Payment to Agent (provide contact info below) ☐Payment to Long-Term Care Home (refer to Section 1)

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

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

Home Telephone Number	Business Telephone Number ext.

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

Section 4 – Physician/Nurse Practitioner's Signature and Confirmation of Eligibility

The following is to be completed by either the Physician or Nurse Practitioner

I certify that the Applicant named above has had a surgical intervention resulting in a permanent ostomy as indicated in Section 2 above.

☐Physician ☐Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing No (6 digits)

Physician/Nurse Practitioner Signature	Date Signed (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.