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 Real-Time Continuous Glucose Monitoring System (rtCGM)

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 rtCGM supplies from:

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

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

Section 2 – Eligibility (to be completed by Physician/Nurse Practitioner)

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

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 diabetes programs. Please confirm that the following Eligibility Criteria have been met:

1. Applicant has Type1 diabetes ☐Yes ☐No

2. Applicant meets one of the following.

   a. Owing to their developmental stage or a previously diagnosed cognitive or physical impairment, Applicant is ☐Yes ☐No ☐N/A

      i. unable to recognize or communicate symptoms of hypoglycemia; or

      ii. independently perform fingerstick glucose testing.

   b. Applicant had severe hypoglycemia in the past 2 years without an obvious precipitant, despite optimized use of insulin therapy and glucose monitoring (at least 4 times/day) which result in one of the following.

      i. suspension of the applicant's driving license ☐Yes ☐No ☐N/A

      ii. hospitalization or emergency room or EMS visit ☐Yes ☐No ☐N/A

      iii. glucagon administration, unconsciousness, or seizure ☐Yes ☐No ☐N/A

3. Applicant demonstrates experience with and commitment to managing blood sugar control and an ability to use rtCGM safely and effectively by ALL of the following.

   a. a commitment to long-term diabetes follow-up through regular assessments by diabetes educators, and prescribers at intervals deemed appropriate by the Diabetes Education Program; ☐Yes ☐No

   b. agrees to full-time rtCGM wear ☐Yes ☐No

   c. agrees to share the data components of the Ambulatory Glucose Profile with the diabetes health care providers/team such as: ☐Yes ☐No

      i. precent time in target range, percent time above or below target range, precent time in hypoglycemia

      ii. visual representation of average 24-hour glucose profile for a 2-week period

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 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 ON - Ontario	Postal Code

Home Telephone Number	Business Telephone Number * ext.

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

Section 4 – Signatures

Physician/Nurse Practitioner Signature

I hereby certify that the applicant has Type 1 diabetes and meets the medical eligibility criteria for rtCGM supplies as outlined in Section 2.

☐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 Diabetes Program providing education

Program Name/Team Name

ADP Clinic Number	Business Telephone Number * ext.

Vendor Information

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.