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 Ventilator Equipment and Supplies

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 Ventilator Equipment or Supplies from:

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

Veterans Affairs Canada (VAC) ☐Yes ☐No

I am a resident of a Long-Term Care Home (LTCH) ☐Yes ☐No

I reside in an acute or a chronic care hospital ☐Yes ☐No

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

Section 2 – Devices and Diagnosis (to be completed by Physician)

Devices/Supplies Required (check as applicable)

☐Ventilator ☐Bilevel Positive Airway Pressure System with backup rate (BPAP-ST) ☐Oxygen Saturation Monitor (OSM)

☐Ventilator Supplies ☐Mechanical In-Exsufflation

Confirmation of Applicant's Medical Eligibility

For Ventilator devices

1. Applicant has a chronic respiratory illness and requires a ventilator for life support	☐Yes	☐No	☐N/A

For BPAP-ST devices

2. Applicant has a chronic respiratory illness and requires a BPAP-ST device with a backup rate	☐Yes	☐No	☐N/A
3. Applicant has a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS), Obesity Hypoventilation, or Central Sleep Apnea (if Yes, provide supporting documentation)	☐Yes	☐No	☐N/A
4. Applicant and/or family is aware that this device is not for life support	☐Yes	☐No	☐N/A

For Oxygen Saturation Monitor devices

5. Applicant is 18 years of age or younger and has a chronic respiratory illness and requires an oxygen saturation monitor	☐Yes	☐No	☐N/A
6. Applicant is unable to notify caregiver and is: a. technologically dependent **and** b. at risk of a profound hypoxemic event	☐Yes	☐No	☐N/A

7. The prescribing physician has privileges at the following hospital(s): (check as applicable)

☐Bloorview Kids Rehab (Toronto) ☐Children's Hospital of Eastern Ontario (Ottawa)

☐Hamilton Health Sciences Centre (Hamilton) ☐The Hospital for Sick Children (Toronto)

☐London Health Sciences Centre (London) ☐Sunnybrook Health Sciences Centre (Toronto)

☐Kingston General Hospital (Kingston)

For Mechanical In-Exsufflation devices

8. Applicant has a diagnosis of neuro-muscular disease, post-polio, spinal cord injury or a condition with weak respiratory muscles or paralysis	☐Yes	☐No	☐N/A
9. Applicant is at risk of or ventilator-assisted	☐Yes	☐No	☐N/A
10. Applicant has documented objective evidence of a weak cough with Peak Cough Flows < 270 L/min with Lung Volume Recruitment and/or Manually Assisted Cough.	☐Yes	☐No	☐N/A

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'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 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 and that I am therefore obliged to retain receipts for a period of two years.

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

If the above signature is not that of the applicant, specify relationship and 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

Home Telephone Number	Business Telephone Number * ext.

Section 4 – Signatures

Physician Signature

I hereby certify that the Applicant has a chronic respiratory illness or disability requiring the long-term use of the device(s) specified above. The Applicant has been instructed and has received training on the use of the equipment.

Physician's Last Name	Physician's First Name

Business Telephone Number * ext.	Ontario Health Insurance Billing Number (6 digits)

Physician's Signature	Date Signed (yyyy/mm/dd)

Provide supporting documentation if required. Other attachments will not be considered by the Assistive Devices Program.

It is an offense punishable by fine and/or imprisonment to knowingly provide false information to obtain funding for a device.