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 Visual Aids

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 Visual Aids from

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

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

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

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

Functional Vision Status (check one)

☐Sight Enhancement (low vision)

☐Sight Substitution (no functional vision)

Devices/Supplies Required (check as appropriate)

Optical Aids	Quantity	Optical Aids	Quantity
☐Magnifier		☐Custom spec mount low vision aids	
☐Illuminated Magnifier		☐Field enhancement visual aid	
☐Monocular		☐Binocular	
☐Monocular Stands and accessories*		☐Specialized lenses	
☐Spectacle-mounted low vision aids		☐Frames for Low Vision Aids*	
☐Spec mount low vision accessories*		☐Contact lenses	

*Devices with exclusions to limit totals

Writing Aids

☐Low-tech writing aid (no options permitted)

High-tech Writing Aids (some options permitted)

☐Personal Information Manager**

Computer systems (options permitted)

☐Computer system – stationary

☐Computer system – portable

Additional Options

☐External Monitor

☐Screen Magnification Software**

☐Speech Synthesizer – Hardware Only

☐Screen Reading Software**

☐Refreshable Braille Display**

☐Braille Translation Software

☐Braille Embosser (printer)**

☐User Support (Writing)

Reading Aids

☐Audio book playback machine

OCR technology

☐Standalone Reader (hardware & software combined)**

☐Hardware** ☐Software**

☐User Support (Reading)

☐CCTV – Optical Enlargement System**

Orientation and Mobility Aids

☐Orientation and Mobility Aid (e.g., standard white cane)

Other

☐Administration Fee (Sight Enhancement; high-tech & cctv only) ☐Shipping Fee

☐Administration Fee (Sight Substitution; high-tech only)

Make and Model Description of devices Authorized (required for those devices marked with **)

Reason for Application (check one)

☐First access to ADP for Visual Aid(s) category

☐Another type of device required in addition to Previously ADP Funded Visual Aid(s)

☐Replacement of Visual Aid(s)

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

Replacement Visual Aid(s) Required Due To (check one)

☐Change in medical condition

☐Physical Growth / Atrophy

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

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

Prescriber's Signature (if applicable)

I hereby certify that the applicant has long-term low vision or blindness that can not be corrected medically, surgically or with ordinary eyeglasses or contact lenses (e.g., corrected vision in the better eye is in the range of 20/70 or less). I therefore confirm that the applicant requires the regular use of the prescribed Visual Aid(s).

☐Physician ☐Optometrist

Physician/Optometrist's Last Name	Physician/Optometrist'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. Based on my assessment of this individual's medical requirements, I have confirmed his/her eligibility for funding assistance in accordance with ADP funding guidelines. I confirm that the client may not use the device solely for educational, vocation and recreational purposes, for computer aided learning or for therapeutic purposes. 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.

Authorizer's Last Name	Authorizer's First Name
Business Telephone Number * ext.	ADP Authorizer Registration Number
	Assessment Date (yyyy/mm/dd)

Clinic (if applicable)

Clinic Name	ADP Clinic Number	Business Telephone Number * ext.

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)

☐Client is pursuing purchase via a non-registered vendor

Provide supporting documentation if required. Other 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.