Ontario

**Ministry of Health**

Assistive Devices Program
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# Real-time Continuous Glucose Monitor Renewal

## Instructions

In order to confirm your ongoing eligibility for coverage for the sensors and transmitter used with the real-time Continuous Glucose Monitor you must complete this form. If approved, you will continue to be eligible for Assistive Devices Program (ADP) coverage for the next 24-months.

Fields marked with an asterisk (*) are mandatory.

## 1. Client's Biographical Information

Last Name *

First Name * | Middle Initial

Health Number (10 digits) * | Version | Date of Birth (yyyy/mm/dd) *

## 2. Ongoing Eligibility Confirmation (To be completed by the ADP-funded client or their agent)

1. I continue to demonstrate a commitment to regular assessments by diabetes prescribers as deemed appropriate by the ADP-registered Diabetes Education Program. * ☐Yes ☐No
2. I wear the real-time Continuous Glucose Monitor for a minimum of 70% of the time. * ☐Yes ☐No
3. I share data components of the Ambulatory Glucose Profile with my diabetes health care provider/team. * ☐Yes ☐No

☐ I certify that the information I have provided on this form is true, correct and completed to the best of my knowledge. I understand that this information is subject to audit. *

Signature

☐Client * ☐Agent *

Date (yyyy/mm/dd) *

**If the signature above is not that of the ADP-funded client, 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.

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| Applicant's Last Name | First Name | Health Number | Version |
|---|---|---|---|
| | | | |

## 3. 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**

| Unit Number | Street Number * | Street Name * |
|---|---|---|
| | | |

| City/Town * | Province ON - Ontario | Postal Code * |
|---|---|---|
| | | |

| | Date (yyyy/mm/dd) * |
|---|---|
| | |

The collection of the information on this form is authorized under the *Ministry of Health Act*, R.S.O. 1990, c.M.26, section 6(1) to determine eligibility for financial assistance under the Assistive Devices Program. For further details concerning this collection, please contact the Program Manager, Assistive Devices Program, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5, telephone 416-327-8804, 1-800-268-6021.