Ontario

Ministry of Health

Request for Change in Vendor

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

Fields marked with an asterisk (*) are mandatory.

Section 1 – Device Category

Device Category *

Section 2 – 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.

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Applicant's Last Name	First Name	Health Number	Version

Section 3 – Applicant's Consent and Signature

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 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**.**

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.

	☐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	Postal Code
ON - Ontario	

Home Telephone Number	Business Telephone Number * ext.

Applicant's Last Name	First Name	Health Number	Version

Section 4 – Vendor/Vendor Representative Information

Current ADP Registered Vendor

Vendor Business Name	ADP Vendor Registration Number

Vendor Location

I hereby certify that I understand that this vendor will no longer receive funding assistance for the client listed above.

Vendor Representative's Last Name	Vendor Representative's First Name

Position / Title	Business Telephone Number * ext.

Date (yyyy/mm/dd)

New ADP Registered Vendor

Vendor Business Name	ADP Vendor Registration Number

Vendor Location

I hereby certify that I understand that this vendor will receive funding assistance for the client listed above.

Vendor Representative's Last Name	Vendor Representative's First Name

Position / Title	Business Telephone Number * ext.

Date (yyyy/mm/dd)

Effective Date of Change

Claim Number (10 digits)	Effective Date (yyyy/mm/dd)

Section 5 – For Real-Time Continuous Glucose Monitoring System Only (To be completed by a Diabetes Education Program (DEP) representative)

I hereby certify that the ADP-registered Diabetes Education Program is aware that there has been a change in vendor

DEP Representative's Last Name	DEP Representative's First Name

Position / Title	Diabetes Education Program Name

Clinic Number	Business Telephone Number * ext.

Date (yyyy/mm/dd)