Ontario

Clear Form

**Ministry of Health and Long-Term Care**
Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Tel: 416 327-8804
1 800 268-6021
TTY: 416 327-4282
TTY: 1 800 387-5559

# Application for Funding Orthotic Devices

*OR1*

## Section 1 – Applicant's Biographical Information

**PLEASE PRINT**

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Health Number *(10 digits)* | Version | Date of Birth *(yyyy/mm/dd)* | Gender |
|---|---|---|---|
| | | / / | ☐ Male ☐ Female |

Name of Long-Term Care Home (LTCH) *(if applicable)*

**Address**

| Building Number | Street Name | Suite/Apt Number |
|---|---|---|
| | | |

| Lot/Concession/Rural Route | City/Town | Postal Code |
|---|---|---|
| | ON | |

| Home Telephone *(include area code)* | Business Telephone *(include area code)* | Ext |
|---|---|---|
| - - | - - | |

## Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If ***yes***, check ☒ one only:

☐ Ontario Works Program (OWP) ☐ Ontario Disability Support Program (ODSP)

☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Orthotic Devices from:

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

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

## Section 2 – Devices and Eligibility

**Diagnosis *(to be completed by Physician)***

**Device(s) Required: *(to be completed by Authorizer)***

| **Cranial** | | **Lower Extremity** | L | R | **Upper Extremity** | L | R | Price Not Listed |
|---|---|---|---|---|---|---|---|---|
| Orthoses | ☐ | Ankle-Foot | ☐ | ☐ | Hand-Finger | ☐ | ☐ | |
| *Additions* | ☐ | Knee-Ankle-Foot | ☐ | ☐ | Wrist-Hand-Finger | ☐ | ☐ | ☐ |
| *Modification* | ☐ | Knee | ☐ | ☐ | Wrist-Hand | ☐ | ☐ | |
| **Spinal** | | Hip-Knee-Ankle-Foot | ☐ | ☐ | Elbow-Wrist-Hand-Finger | ☐ | ☐ | |
| Cervical | ☐ | Hip | ☐ | | Elbow | ☐ | ☐ | |
| Cervico-Thoraco-Lumbo-Sacral | ☐ | Standing Frames | ☐ | | Shoulder-Elbow | ☐ | ☐ | ☐ |
| Cranial-Cervical-Thoracic | ☐ | Reciprocating Gait Mech* | ☐ | | Shoulder-Elbow-Wrist-Hand-Finger* | ☐ | ☐ | ☐ |
| Thoraco-Lumbo-Sacral | ☐ | *Additions* | ☐ | | *Additions* | ☐ | | |
| Lumbo-Sacral | ☐ | *Components* | ☐ | | *Components* | ☐ | | |
| Scoliosis | ☐ | *Modification* | ☐ | | *Modification* | ☐ | | |
| *Additions* | ☐ | | | | | | | |
| *Modification* | ☐ | | | | | | | |

***Highly Specialized Orthoses**

  Disponible en Français 

| Applicant's Last Name, First Name *(PLEASE PRINT)* | Health Number | Version |
|---|---|---|
| | | |

**Reason for Application *(check one)* *(to be completed by Authorizer)***

- ☐ First access to ADP for Orthotic Devices
- ☐ Additions and Components for Orthotic Device(s)
- ☐ Replacement of Previously ADP Funded Orthotic Device(s)
- ☐ Modification or Adjustments to Orthotic Device(s) *(complete Modifications section below)*

**Replacement and/or Modification Required Due To: *(check as applicable)* *(to be completed by Authorizer)***

- ☐ Change in medical condition
- ☐ Physical growth/atrophy
- ☐ Normal wear *(and applicant confirms that it is no longer under warranty)*

**Modification or Adjustment Required: *(complete if applicable)* *(to be completed by Vendor)***

Device being modified:

Description of modification required: *(Note: Cost of Modification must be a minimum of $100 and cannot exceed 30% of the replacement cost)*

Technical Time: _____ Hours Clinical Time: _____ Hours Materials cost: $_____ Total Cost: $_____

**Special Approval Requested – Price Not Listed: *(complete if applicable)* *(to be completed by Vendor)***

| ☐ Applicant requires an orthosis whose price is not listed in the ADP Product Manual | Device required: |
|---|---|

Technical Time: _____ Hours Clinical Time: _____ Hours Materials cost: $_____ Total Cost: $_____

**Special Approval Requested – Hybrid Device: *(complete if applicable)* *(to be completed by Authorizer)***

| ☐ Applicant requires a hybrid device (combination orthotic / prosthetic device) | Device required: |
|---|---|

**Confirmation of Applicant's Eligibility:** *(answer required)* ***(to be completed by Authorizer)***

| | | |
|---|---|---|
| 1. Applicant has a long-term physical disability related to their diagnosis | ☐ Yes | ☐ No |
| 2. Applicant requires the use of an orthosis on an ongoing daily basis to improve function in a variety of activities of daily living | ☐ Yes | ☐ No |

## 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 and Long-Term Care (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.

| Signature<br>**X** | ☐ Applicant ☐ Agent | Date *(yyyy/mm/dd)*<br>/ / |
|---|---|---|

**If signature above is not that of the applicant, specify relationship and complete contact information below**

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Public Trustee ☐ Power of Attorney

**PLEASE PRINT**

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

**Address**

| Building Number | Street Name | Suite/Apt Number |
|---|---|---|
| | | |

| Lot/Concession/Rural Route | City/Town | Province | Postal Code |
|---|---|---|---|
| | | | |

| Home Telephone *(include area code)* | Business Telephone *(include area code)* | Ext |
|---|---|---|
| - - | - - | |

| Applicant's Last Name, First Name *(PLEASE PRINT)* | Health Number | Version |
|---|---|---|
| | | |

## Section 4 – Signatures
## Prescriber's Signature *(if applicable)*

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic physical disability requiring the regular use of the prescribed Orthotic Device(s).

**PLEASE PRINT**

| Physician's Last Name | Physician's First Name |
|---|---|
| | |

| Business Telephone *(include area code)* | Ext | Ontario Health Insurance Billing No *(6 digits)* |
|---|---|---|
| - - | | |

| Physician's Signature | Date Signed *(yyyy/mm/dd)* |
|---|---|
| X | / / |

## 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 all ADP funding guidelines. 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.

**PLEASE PRINT**

| Authorizer's Last Name | Authorizer's First Name |
|---|---|
| | |

| Business Telephone *(include area code)* | Ext | ADP Authorizer Registration Number |
|---|---|---|
| - - | | - |

| Authorizer's Signature | Assessment Date *(yyyy/mm/dd)* |
|---|---|
| X | / / |

## Rehabilitation Assessor Signature *(if applicable)*

I certify that I have conducted a rehabilitation assessment of the applicant. I confirm that the applicant requires the use of the indicated Orthotic Device(s) for a range of daily activities within the ADP eligibility guidelines.

**PLEASE PRINT**

| Rehabilitation Assessor's Last Name | Rehabilitation Assessor's First Name |
|---|---|
| | |

| Business Telephone *(include area code)* | Ext | ADP Authorizer Registration Number |
|---|---|---|
| - - | | - |

| Rehabilitation Assessor's Signature | Assessment Date *(yyyy/mm/dd)* |
|---|---|
| X | / / |

## 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 |
|---|---|
| | |

**PLEASE PRINT**

| Vendor Representative's Last Name | Vendor Representative's First Name |
|---|---|
| | |

| Position Title | Business Telephone *(include area code)* | Ext |
|---|---|---|
| | - - | |

Vendor Location

| Vendor Representative's Signature | Date *(yyyy/mm/dd)* |
|---|---|
| X | / / |

**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.**

Print Form