Ontario

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 Ventilator Equipment & Supplies

VE1

Clear Form

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 Ventilator Equipment or Supplies from:

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

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

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

I am a patient of an acute or a chronic care hospital ☐ Yes ☐ No

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

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 does not have a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS), Obesity Hypoventilation, or Central Sleep Apnea (if No, provide supporting documentation)	☐ Yes	☐ No	☐ N/A
4. Applicant does not require this device for life support (and applicant and/or family has been made aware)	☐ Yes	☐ No	☐ N/A

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

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:
i) technologically dependent AND
ii) 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) ☐ Yes ☐ No ☐ N/A
☐ London Health Sciences Centre (London) ☐ Sunnybrook Health Sciences Centre (Toronto)
☐ Kingston General Hospital (Kingston)

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

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

PLEASE PRINT

Last Name	First Name	Middle Initial

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
- -	- -	

Section 4 – Signatures

Physician's 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.

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	/ /

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 for a device.

Print Form