

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 – Applicant's Biographical Information

Last Name *

First Name *

Middle Initial

Health Number (10 digits)

Version

Date of Birth (yyyy/mm/dd)

Sex

Male

Female

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

Address

Unit Number

Street Number

Street Name *

Lot/Concession/Rural Route *

City/Town *

Province *

ON

Postal Code *

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 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/Nurse Practitioner)

Device(s) Required: (to be completed by Authorizer)**Cranial**
 Orthoses Additions Modification
Spinal
 Cervical Cervico-Thoraco-Lumbo-Sacral Cranial-Cervical-Thoracic Thoraco-Lumbo-Sacral
 Lumbo-Sacral Scoliosis Additions Modification
Lower Extremity

Ankle-Foot	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Hip	<input type="checkbox"/> Standing Frames
Knee-Ankle-Foot	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Reciprocating Gait Mech*	<input type="checkbox"/> Additions
Knee	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Components	<input type="checkbox"/> Modification
Hip-Knee-Ankle-Foot	<input type="checkbox"/> Left <input type="checkbox"/> Right		

Upper Extremity

Hand-Finger	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Additions
Wrist-Hand-Finger	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Components
Wrist-Hand	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Modification
Elbow-Wrist-Hand-Finger	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Elbow	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Shoulder-Elbow	<input type="checkbox"/> Left <input type="checkbox"/> Right	
Shoulder-Elbow-Wrist-Hand-Finger*	<input type="checkbox"/> Left <input type="checkbox"/> Right	

Price Not Listed
 Wrist-Hand-Finger Shoulder-Elbow Shoulder-Elbow-Wrist-Hand-Finger*
Highly Specialized Orthoses*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)

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Technical Time _____ Hours	Clinical Time _____ Hours	Material Cost _____	Total Cost _____
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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	Material Cost _____	Total Cost _____
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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

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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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.

Signature	<input type="checkbox"/> Applicant * <input type="checkbox"/> Agent *	Date (yyyy/mm/dd)
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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
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Address	
Unit Number	Street Number

Street Name

Lot/Concession/Rural Route

City/Town

Province ON	Postal Code
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Home Telephone Number	Business Telephone Number	ext.
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Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Section 4 – Signatures

Physician/Nurse Practitioner 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).

Physician Nurse Practitioner

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name
Business Telephone Number ext.	Ontario Health Insurance Billing No (6 digits)
Physician/Nurse Practitioner's Signature	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 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.

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

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.

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

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 Boundless Biomechanical Bracing	ADP Vendor Registration Number 151746
Vendor Representative's Last Name Blocka	Vendor Representative's First Name Dan
Position Title Certified Orthotist / President	Business Telephone Number 905-602-0650 ext.
Vendor Location Mississauga	
Vendor Representative's Signature	Date (yyyy/mm/dd)

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.