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

It is an offense punishable by fine and/or imprisonment to knowingly provide false information to obtain funding for a device.

Section 1 - Applicant's Biographical Information

PLEASE PRINT

Last Name	First Name	Middle Initial

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

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

Address Building Number	Street Name	Type *(St/Blvd/ Ave/Dr/Cr)*	Direction *(N/S/W/E)*	Suite/Apt Number

Lot/Concession/Rural Route	City/Town	Province	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) ☐ 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 ☐ Mechanical In-Exsufflation

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 has completed a Level 1 sleep study and does not have a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS), Obesity Hypoventilation, or Central Sleep Apnea ☐ Yes ☐ No ☐ N/A

4. Applicant does not require this device for life support (and family has been made aware) ☐ Yes ☐ No ☐ N/A

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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 OR 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) ☐ London Health Sciences Centre (London) ☐ Sunnybrook Health Sciences Centre (Toronto) ☐ Kingston General Hospital (Kingston)	☐ Yes	☐ No	☐ N/A
For Mechanical In-Exsufflation devices:			
8. Applicant has a diagnosis of neuro-muscular disease, post-polio, spinal cord injury or a condition with weak respiratory muscles or paralysis	☐ Yes	☐ No	☐ N/A
9. Applicant is at risk of or ventilator-assisted	☐ Yes	☐ No	☐ N/A
10. Applicant has documented objective evidence of a weak cough with Peak Cough Flows < 270 L/min with Lung Volume Recruitment and/or Manually Assisted Cough.	☐ Yes	☐ No	☐ N/A

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

The Ministry of Health and Long-Term Care's (the Ministry) collection of the personal health information on or attached to this form is necessary for the purpose of assessing and verifying eligibility for the Assistive Devices Program, and for all other purposes related to the proper administration of that Program.

This information may be used or disclosed in accordance with the *Personal Health Information Protection Act*, 2004, as set out in the Ministry's "Statement of Information Practices" which is accessible at: www.health.gov.on.ca .

Applicants may withhold their consent to the collection of this information; however, doing so will interfere with their coverage under the Assistive Devices Program.

For more information on the Ministry's Information Practices, or the collection of the personal health information on this form, call 1 800 268-6021 or 416 327-8804 or write to the Program Manager, 5700 Yonge Street, 7th floor, Toronto ON M2M 4K5.

I consent to the collection and disclosure of medical and non-medical information for the purpose of assessing and verifying eligibility for the Assistive Devices Program, and for all other purposes related to the proper administration of that Program.
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 and that I am therefore obliged to retain receipts for a period of two years.

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

If the above signature is not that of the applicant, specify relationship of the signer to applicant and fill out contact information

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

PLEASE PRINT

Last Name	First Name	Middle Initial

Address

Building Number	Street Name	Type *(St/Blvd/ Ave/Dr/Cr)*	Direction *(N/S/W/E)*	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	/ /

Note: Attachments will not be considered by the Assistive Devices Program

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Addendum for Ventilator Equipment and Supplies Application form

To be completed by the prescribing physician/delegate to facilitate processing of a request for ventilator equipment and supplies

Client Name: ____

Last name *First name*

Client Health Card Number: ________________________

Diagnosis:

☐Neuromuscular disorders:
- ☐ Amyotrophic lateral sclerosis ☐ Muscular dystrophy, *please specify*: ________________________
- ☐ Diaphragm paralysis ☐ Myasthenia gravis ☐ Guillain-Barré syndrome ☐ Spinal Cord Injury
- ☐ Other: *please specify:*___________________________

☐Chest wall deformities:
- ☐ Kyphoscoliosis ☐ Fibrothorax ☐ Thoracoplasty ☐ Thoracic Resection
- ☐ Other: *please specify*:________________________

☐Central respiratory drive depression:
- ☐ Drugs – (eg. Narcotics) ☐ Neurologic disorders (eg. trauma, stroke, multiple sclerosis)
- ☐ Primary alveolar hypoventilation

☐Obesity hypoventilation syndrome ☐ OTHER: *please specify*:__________________________

☐Obstructive Sleep Apnea Syndrome (OSAS):
- ☐ Complicated OSAS ☐ CPAP intolerant ☐ CPAP-emergent Central apnea

☐Chronic obstructive pulmonary disease (COPD)

Note:
Prescribing physician's letter explaining need for rate must accompany application if diagnosis is OSAS/ Obesity Hypoventilation or Central Sleep Apnea.

Equipment Details:

Ventilator Type: ________________________ Quantity: ☐ 1 ☐ 2

Ventilator Settings: ____

Ventilator Interphase: _____________________

BiPap ST Settings: IP___ EP ___ Rate ___ Humidifier: ☐ Yes ☐ No
Quantity: ☐ 1 ☐ 2

Hours of Ventilation/Ventilation Assist: ☐ <12 ☐ 12-24 ☐ 24

Battery: ☐ Yes ☐ No Charger: ☐ Yes ☐ No Cable: ☐ Yes ☐ No

Saturation Monitor: Start Date *(yyyy/mm/dd)*: _____/___/___ End Date *(yyyy/mm/dd)*: _____/___/___ *(max of 2 years)*

Equipment Delivery Instructions:

Deliver to: ☐ client's home ☐ facility

Facility Name: ____________________ Address: ____

Floor number: _____ Room number: ______

Facility contact person: _________________________ Phone #: ____ -____- ______ Ext. _______