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 Mobility Devices

MD1

Section 1 - Applicant's Biographical Information

PLEASE PRINT

Last Name	First Name	Middle Initial
YOUNG	SUZANNE	

Health Number (10 digits)	Version	Date of Birth (yyyy/mm/dd)	Gender
6427951512	YW	1964/10/11	☐ Male ☒ Female

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

Address

Building Number	Street Name	Suite/Apt Number
34	ATHENIA DR	

Lot/Concession/Rural Route	City/Town		Postal Code
	STONEY CREEK	ON	L8J 1S6

Home Telephone (include area code)	Business Telephone (include area code)	Ext.
905-661-0395	- -	

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 Mobility Devices from:

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

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

Section 2 – Devices and Eligibility *(to be completed by Authorizer)*

Applicant's presenting medical condition - MUST BE COMPLETED	Applicant's basic functional mobility status related to the need for an ADP funded device - MUST BE COMPLETED
Acquired Brain Injury; Vertigo OA; Asthma; hypoglycemia; hiatus hernia; multiple #'s (L) foot following several falls; sleep apnea	↓ balance; S.O.B; unsteady gait; dizziness; ↓ standing balance/tolerance; ↓ strength/endurance; ↑ risk for further falls/injury; unable to ambulate safely.

Section 2 – Devices and Eligibility *(to be completed by Authorizer)*

Mobility Equipment Previously Funded by ADP ***(check one or more as appropriate)***

☒ None	☐ Forearm crutches	☐ Power add on device	☐ Power recline system
	☐ Wheeled walker	☐ Power scooter	☐ Power elevating leg rests
	☐ Manual wheelchair	☐ Positioning devices (seating)	☐ Paediatric standing frame
	☐ Power wheelchair	☐ Power tilt system	☐ Paediatric specific specialty stroller

This page must be completed and submitted

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version
YOUNG, SUZANNE	6 4 2 7 9 5 9 5 1 2	Y 0

Device(s) Currently Required by the Applicant on an ongoing daily basis, Based on Eligibility Criteria for ADP Funding Assistance

(check one or more as appropriate)	*Complete and submit the relevant Section(s) below:*
☐ Forearm crutches only to achieve independent mobility	**Section 2a**
☒ A wheeled walker only to achieve independent mobility	**Section 2a**
☐ A manual wheelchair only to achieve independent mobility	**Section 2b**
☐ An ambulation aid and a manual wheelchair to achieve independent mobility	**Section 2a and Section 2b**
☐ A manual wheelchair to achieve mobility (dependent for propulsion)	**Section 2b**
☐ A manual dynamic tilt wheelchair to achieve independent mobility	**Section 2b**
☐ A manual dynamic tilt wheelchair to achieve mobility (dependent for propulsion)	**Section 2b**
☐ A manual wheelchair with a power add-on device to achieve independent mobility	**Section 2b**
☐ A power base only to achieve independent mobility	**Section 2c**
☐ A power scooter only to achieve independent mobility	**Section 2c**
☐ An ambulation aid and a power base/scooter to achieve independent mobility	**Section 2a and Section 2c**
☐ Positioning devices (seating) for a wheelchair - modular and/or custom fabricated	**Section 2d**
☐ A high technology power base (dynamic tilt and/or recline and/or power elevating leg rests) – ***attach justification for funding chart***	**Section 2c**
☐ A paediatric standing frame	**Section 2a**
☐ Modifications to previously ADP funded device(s)	**Section 2a/ambulation aid, Section 2b/manual wheelchair, Section 2c/power wheelchair**
☐ Modifications to non ADP funded device(s)	**Section 2a/ambulation aid, Section 2b/manual wheelchair, Section 2c/power wheelchair**

This page must be completed and submitted

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version
YOUNG, SUZANNE	6 4 2 7 9 5 9 5 1 2	Y W

Section 2a - Ambulation Aids

Base Device *(check one walker and/or forearm crutches and/or one paediatric standing frame)*

- ☐ Adult Wheeled Walker Type 1
- ☐ Adult Wheeled Walker Type 2
- ☒ Adult Wheeled Walker Type 3
- ☐ None
- ☐ Paediatric Specific Wheeled Walker Type 1
- ☐ Paediatric Specific Wheeled Walker Type 2
- ☐ Paediatric Specific Wheeled Walker Walking Frame
- ☐ Paediatric Standing Frame Type 1
- ☐ Paediatric Standing Frame Type 2
- ☐ Forearm Crutches

Reason for Application *(check one)*

- ☒ First access for Mobility Devices
- ☐ Another type of device required in addition to Previously ADP Funded Device(s)
- ☐ Modifications to Non ADP Funded Device(s)
- ☐ Replacement of Previously ADP Funded Device(s) no longer in use
- ☐ Modifications/Adjustments /Additional Components to Previously ADP Funded Device(s) currently in use

Replacement Device(s) and/or Modifications Required Due To: *(check as appropriate)*

- ☐ Change in applicant's mobility status - previously ADP funded equipment no longer meeting basic mobility needs as defined by ADP for funding purposes
- ☐ Change in applicant's body size - previously ADP funded equipment is either too large or too small.
- ☐ Previously ADP funded equipment is worn out **- attach vendor quote and/or copies of repair bills for wheeled walkers and wheelchairs only.**
- ☐ Special circumstances - none of the above - **attach letter of rationale.**

Confirmation of Applicant's Eligibility for Ambulation Aids (*answer required for each statement*)

	Yes	No	N/A
1. Applicant requires the prescribed device in order to move throughout his/her place of residence.	☒	☐	☐
2. Applicant requires the prescribed device in order to move beyond his/her place of residence.	☒	☐	☐
3. Applicant requires the prescribed device to access wheelchair inaccessible areas in his/her place of residence.	☐	☐	☒
4. Applicant is independently mobile with the prescribed device.	☒	☐	☐
5. Applicant requires forearm crutches.	☐	☒	☐
6. Applicant requires a paediatric specific standing frame.	☐	☒	☐

Section 2a continued

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version
YOUNG, SUZANNE	6 4 2 7 9 5 9 5 1 2	Y W

Prescription Details for Wheeled Walker Only: ***(answers required for all specifications)***

1. Seat Height:	22	☐ cm or	☒ inches	☐ N/A
2. Push Handle Height:	35	☐ cm or	☒ inches	
3. Hand Grips	☐ None	☒ Standard	☐ Anatomical	Forearm Attachments ☐ One ☐ Two
4. Width Between Push Handles	18	☐ cm or	☒ inches	
5. Client Weight	240	☐ kg or	☒ lbs	
6. Brakes	☐ None	☒ Push -To-Lock	☐ Auto Stop	
7. Brake Type	☐ None	☒ Bilateral	☐ One Hand	
8. Number of Wheels	☐ Two	☐ Three	☒ Four	
9. Wheel Size	☐ 4-6 inches	☐ 6-8 inches	☒ 8-10 inches	
10. Back Support	☒ Yes	☐ No		

Additional ADP Funded Options Required for Prescribed Device ***(if applicable check one or more)***

☐ Adolescent Size Paediatric Specific Wheeled Walker

☐ Adolescent Size Paediatric Wheeled Walker – Walking Frame

☐ Adolescent Size Paediatric Standing Frame

Non ADP Funded Options Prescribed ***(Optional)***

Set Up Instructions for Vendor ***(Optional)***

☐ **Custom Modifications Required**

The authorizer must provide clinical rationale to support the request in the space below and attach a vendor quote that provides a breakdown of the cost of labour (not to exceed $40.00/hour) and parts.

Applicant's Last Name, First Name *(PLEASE PRINT)*: YOUNG, SUZANNE

Health Number *(10 digits)*: 6427959512 | Version: YW

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 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: X Suzanne Young | ☒ Applicant ☐ Agent | Date *(yyyy/mm/dd)*: 2014 09 25

If the above signature is not that of the applicant, specify relationship 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 | 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

Authorizer's Signature

I hereby certify that I have personally assessed the applicant named on this form in person, I have confirmed his/her eligibility for funding assistance in accordance with all ADP funding guidelines, I have authorized the equipment described on this form based on a comprehensive clinical assessment, and have taken all safety and environmental concerns into consideration. I have advised the applicant or his/her agent that (i) 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 or (ii) have informed the applicant or his/her agent about the policies and procedures of the ADP Central Equipment Pool for High Technology Wheelchairs (CEP).

PLEASE PRINT

Authorizer's Last Name *(PLEASE PRINT)*: HAMILTON | Authorizer's First Name *(PLEASE PRINT)*: MARTIN

Business Telephone *(include area code)*: 905-529-0521 | Ext. | ADP Authorizer Registration Number: 2010010004-

Authorizer's Signature: X [signature] | Assessment Date *(yyyy/mm/dd)*: 2014 09 25

This page must be completed and submitted

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

PLEASE PRINT

1. Vendor Business Name: MOTION SPECIALTIES | Vendor's ADP Registration Number:

I hereby certify that the equipment as prescribed has been provided or will be provided to the applicant

Vendor/Representative *(Last Name, First Name)* | Position / Title

Vendor Location

Vendor/Representative Signature	Date *(yyyy/mm/dd)*	Business Telephone *(include area code)*	Ext.
X	/ /	- -	

2. Vendor Business Name | Vendor's ADP Registration Number:

I hereby certify that the equipment as prescribed has been provided or will be provided to the applicant

Vendor/Representative *(Last Name, First Name)* | Position / Title

Vendor Location

Vendor/Representative Signature	Date *(yyyy/mm/dd)*	Business Telephone *(include area code)*	Ext.
X	/ /	- -	

Equipment Specifications *(Ambulation Aids Only)*

Vendor Invoice Number	Vendor's ADP Registration Number	Base Device	
		ADP Portion	Client Portion
		$	$

ADP Device Code (Base Device)	Description of Item *(Make & Model)*	Serial Number

Proof of Delivery

I confirm that I have received the mobility device described above and that I have received a fully itemized invoice from the vendor for the device described above. I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

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

Pages and Attachments Being Submitted

NOTE to ADP Registered Authorizer:

1. **Complete this application form in full according to applicant's eligibility for ADP funding assistance and make a copy for your records.**
2. Check the following pages/sections of the application form **and** the attachments that are included with your submission:
   - ☒ Section 1 - Applicant's Biographical Information & Confirmation of Eligibility ***(Section 1 must be completed and submitted)***
   - ☒ Section 2a - Ambulation Aids
   - ☐ Section 2b - Manual Wheelchairs
   - ☐ Section 2c - Power Bases & Power Scooters
   - ☐ Section 2d - Positioning Devices *(Seating)* for Mobility
   - ☒ Section 3 and Section 4 – Consent and Signatures ***(Sections 3 and 4 must be completed and submitted)***
3. Attachments ***(if required)*** ***Note: Other attachments will not be considered by the Assistive Devices Program***
   - ☐ Vendor Quote - Replacement of ADP funded equipment due to normal wear and tear
   - ☐ Vendor Quote - Custom Modifications to ADP Listed Device
   - ☐ Justification for Funding Chart - Dynamic Positioning Device *(power tilt and/or recline and/or power elevating leg rests)*
   - ☐ Letter of Rationale - Extenuating Circumstances Only
4. **Application form may be submitted to ADP once all signatures are obtained – applicant/agent, authorizer and vendor(s).**

This page must be completed and submitted

It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding.

McMaster University

Michel P. Rathbone
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NEUROLOGY
HENDERSON GENERAL HOSPITAL
711 CONCESSION ST., HAMILTON, ONT. L8C 1V3

TEL: (905) 574-8630 FAX: (905) 383-3958

Name (Family, First): Young,Suzanne
Address: 34 Athenia Dr, Stoney Creek, ON, L8J 1S3
Telephone: (905) 661-0395
Date of Birth (mm:dd:yy): 10/11/64
OHIN: 6427 959 512 YW
Family Physician: Di Paolo, B

1. Walking cane with grip
2. Wheeled walker.

To assist with balance.

Signature _____

- REPEAT	1	2	3	4	5		NR