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
Toll-Free: 1 800 268-6021
TTY: 416 327-4282
TTY: 1 800 387-5559

Application for Funding Pressure Modification Devices

PM1

Section 1 – Applicant's Biographical Information

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

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code
		ON	

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 Pressure Modification 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 where applicable)

☐ Hypertrophic Scarring

Chronic Lymphedema

☐ Primary ☐ Secondary

Surgical Procedure (if applicable)	Date of Surgery (yyyy/mm/dd)

Section 2a - Hypertrophic Scar Management Devices (to be completed by Authorizer)

Device(s) Required:

Mask

☐ Face Mask ☐ Chin Strap / Neck Support ☐ Accessories

Trunk

☐ Vest - sleeveless ☐ Vest - short sleeves ☐ Vest - two sleeves ☐ Chest Brace / Bolero

☐ Body Brief - sleeves ☐ Body Brief - sleeveless ☐ Body Brief - legs ☐ Body Brief - legs & sleeves

☐ **Options - Garments**

☐ **Interim Care Garments**

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

Lower Extremity

Foot Gloves	☐ Left	☐ Right	☐ Stockings - waist high (two legs)	☐ Stockings - chest high
Anklet / Sock	☐ Left	☐ Right	☐ Panty Girdle	☐ Penile Support
Leg Tube	☐ Left	☐ Right	☐ Stockings - chaps style (two legs)	
Stockings - knee length	☐ Left	☐ Right		
Stockings - thigh length	☐ Left	☐ Right		
Stockings - waist high (one leg)	☐ Left	☐ Right		
Stockings – chaps style (one leg)	☐ Left	☐ Right		

Upper Extremity

Mittens	☐ Left	☐ Right
Gauntlet	☐ Left	☐ Right
Glove	☐ Left	☐ Right
Finger Supports	☐ Left	☐ Right
Half Sleeve	☐ Left	☐ Right
Sleeve	☐ Left	☐ Right
Sleeve with shoulder flap	☐ Left	☐ Right

Orthotics

Wrist-hand-finger	☐ Left	☐ Right	☐ Face Mask	
Elbow-wrist-hand-finger	☐ Left	☐ Right	☐ Neck Brace	
Elbow-wrist-hand-finger (bi-valved)	☐ Left	☐ Right		
Axilla Splint	☐ Left	☐ Right		
Ankle-foot	☐ Left	☐ Right		
Ankle-foot (bi-valved)	☐ Left	☐ Right		

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

☐ First access to ADP for Hypertrophic Scar Management Devices

☐ Additional Devices/Options to other ADP Funded Hypertrophic Scar Management Devices

☐ Replacement of Previously ADP Funded Hypertrophic Scar Management Devices

Replacement Required Due To: (check as applicable) (to be completed by Authorizer)

☐ Change in medical condition

☐ Physical Growth/Atrophy or tissue healing

☐ Normal wear and applicant confirms that it is no longer under warranty

Confirmation of Applicant's Eligibility for Hypertrophic Scar Management Devices (to be completed by Authorizer)

Applicant requires a compression garment and/or a compression orthosis for hypertrophic scar management for a minimum of six (6) months of regular daily use. ☐ Yes ☐ No ☐ N/A

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

Section 2b – Lymphedema Management Devices (to be completed by Authorizer)

Device(s) Required:

Mask

☐ Face Mask ☐ Chin Strap / Neck Support ☐ Accessories

Trunk

☐ Vest - sleeveless ☐ Vest - short sleeves ☐ Body Brief - sleeveless ☐ Body Brief - sleeves

☐ **Options - Garments**

Lower Extremity

Foot Gloves	☐ Left	☐ Right	☐ Stockings - waist high (two legs)
Foot Cap	☐ Left	☐ Right	☐ Stockings - chest high
Stockings – foot to knee	☐ Left	☐ Right	☐ Stockings - chaps style (two legs)
Stockings – foot to thigh	☐ Left	☐ Right	
Stockings – foot to thigh with waist attachment	☐ Left	☐ Right	
Stockings - waist high (one leg)	☐ Left	☐ Right	
Stockings – chaps style (one leg)	☐ Left	☐ Right	

Upper Extremity

Glove	☐ Left	☐ Right
Gauntlet	☐ Left	☐ Right
Arm Sleeve – ½	☐ Left	☐ Right
Arm Sleeve – ½ with glove	☐ Left	☐ Right
Arm Sleeve – full	☐ Left	☐ Right
Arm Sleeve – full with glove	☐ Left	☐ Right
Arm Sleeve – with shoulder flap	☐ Left	☐ Right
Arm Sleeve - with shoulder flap & glove	☐ Left	☐ Right

Compression Sleeves

Upper Extremity	☐ Left	☐ Right	☐ Gauge
Glove	☐ Left	☐ Right	
Lower Extremity	☐ Left	☐ Right	
Lower ½ Extremity	☐ Left	☐ Right	

Sequential Extremity Pumps & Accessories

☐ Sequential Extremity Pump ☐ Medical Overlapping Pants ☐ Accessories

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

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

- ☐ First access to ADP for Lymphedema Management Devices
- ☐ Additional Devices/Options to other ADP Funded Lymphedema Management Devices
- ☐ Replacement of Previously ADP Funded Lymphedema Management Devices

Replacement Required Due To: (check as applicable) (to be completed by Authorizer)

- ☐ Change in medical condition
- ☐ Physical Growth/Atrophy or tissue healing
- ☐ Normal wear and applicant confirms that it is no longer under warranty

Confirmation of Applicant's Eligibility for Lymphedema Management Garments/Sleeves (to be completed by Authorizer)

1.	Applicant has chronic primary or secondary lymphedema and requires a graduated compression garment for a minimum of six (6) months of regular daily use.	☐ Yes	☐ No	☐ N/A
2.	Applicant has chronic lymphedema and requires the use of a compression sleeve for longer than six (6) months of daily/nightly use, in conjunction with the use of graduated compression garments. Applicant's edema cannot be managed effectively with the use of nighttime bandaging.	☐ Yes	☐ No	☐ N/A

Confirmation of Applicant's Eligibility for Sequential Extremity Pumps/Accessories (to be completed by Authorizer)

3.	Applicant has primary lymphedema.	☐ Yes	☐ No	☐ N/A
4.	Applicant requires the use of a Sequential Extremity Pump for a minimum of five (5) days per week and a minimum of two (2) hours per day.	☐ Yes	☐ No	☐ N/A

Continue on next page

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

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

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

☐ Spouse

☐ Parent

☐ Legal Guardian

☐ Public Trustee

☐ Power of Attorney

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code
		ON	

Home Telephone Number	Business Telephone Number ext.

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 regular use of the prescribed pressure modification 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)

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

Authorizer's Signature and Confirmation of Applicant's Eligibility

I hereby certify that I have personally assessed the applicant in person and determined that the applicant meets ADP eligibility criteria. I have also measured and/or authorized the equipment described on this form and advised the applicant or his/her agent that he/she may purchase the device through an 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)

Certified Fitter's Signature

I hereby certify that as recommended by the Physician/Nurse Practitioner/Authorizer/Burn Team/Lymphedema Team, I have measured the applicant named above and subsequently fitted the pressure modification device to the applicant's satisfaction. I have also trained the applicant on how to apply, remove, use, care for, and maintain the device.

Fitter's Last Name	Fitter's First Name
Business Telephone Number ext.	ADP Certified Fitter's Registration Number
Fitter's Signature	Final Fitting Date (yyyy/mm/dd)

Clinic (if applicable)

Clinic Name

ADP Clinic Number	Business Telephone Number ext.

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
Vendor Representative's Last Name	Vendor Representative's First Name
Position Title	Business Telephone Number ext.

Vendor Location

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.