

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Section 2d - Apnea/Cardiorespiratory Monitors

Device (check one)

- ☐ Apnea/Cardiorespiratory Monitor Rental *note – maximum six month rental
- ☐ Apnea/Cardiorespiratory Monitor Purchase

Confirmation of Applicant's Eligibility (answer questions 1-3 for monitor rental; 4 for monitor purchase)

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|--|------------------------------|-----------------------------|------------------------------|
| 1. Applicant is the sibling of a Sudden Infant Death Syndrome (SIDS) Infant. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2. Applicant is an infant who has experienced an Apparent Life-Threatening Episode (ALTE). | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 3. Applicant is a premature infant in whom apnea persists beyond 37 weeks corrected gestational age. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 4. Applicant has a Tracheostomy (purchase only). | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

Section 2e – Airway Clearance Devices

Device (check one or more as appropriate)

- ☐ Postural Drainage Board
- ☐ Percussor

Reason for Application (check one)

- ☐ First access for Airway Clearance Devices
- ☐ Replacement of Previously ADP Funded Device(s)

Replacement Device(s) Required Due To (check as appropriate)

- ☐ Change in applicant's medical/respiratory status - previously ADP funded equipment no longer meeting basic respiratory needs as defined by ADP for funding purposes
- ☐ Previously ADP funded equipment is not in good working order and client confirms that it is no longer under warranty - attach repair quote and/or copies of repair bills

Confirmation of Applicant's Eligibility for an Airway Clearance Device (answer required)

Applicant has cystic fibrosis ☐ Yes ☐ No ☐ N/A

Section 2f – Tracheostomy Equipment

Equipment (check one or more as appropriate)

- ☐ Tracheostomy Tubes
- ☐ Speaking Valves
- ☐ Other Tracheostomy Supplies

Confirmation of Applicant's Eligibility For Tracheostomy Equipment or Supplies (answer required)

Applicant has undergone a tracheostomy ☐ Yes ☐ No ☐ N/A