

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Section 2b – Compressors

Device (check one or more as appropriate)

- ☐ Medication Compressor - Portable
- ☐ Medication Compressor - Stationary
- ☐ High Output Air Compressor

Reason for Application (check one)

- ☐ First access for Compressors
- ☐ 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 A Compressor

(answer all questions)

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| 1. Applicant has cystic fibrosis. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2. Applicant is receiving inhaled antibiotics. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 3. Applicant has a physical disability that prevents them from using a powdered delivery or metered-dose form of medication. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 4. Applicant has not yet developed the co-ordination required to operate powdered delivery or metered-dose devices. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 5. Applicant has a permanent or long-term tracheostomy and requires high humidification of inspired air. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 6. Applicant has a permanent tracheostomy and requires inhaled aerosolized antibiotics. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

Section 2c – Suction Devices

Device (check one or more as appropriate)

- ☐ Stationary Suction Unit
- ☐ Portable Suction Unit
- ☐ Suction Supplies

Reason for Application (check one)

- ☐ First access for Suction 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 a Suction Device and/or Supplies

(answer required for each question)

- | | | | |
|---|------------------------------|-----------------------------|------------------------------|
| 1. Applicant has a chronic respiratory illness or disability requiring the long-term use of a suction device. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2. Applicant requires a portable suction device. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |