

Fields marked with an asterisk (*) are mandatory.

Section 1 – Applicant's Biographical Information

Last Name *

First Name *

Middle Initial

Health Number (10 digits)

Version

Date of Birth (yyyy/mm/dd)

Sex

☐ 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 *

ON

Postal Code *

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 Respiratory 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 reside in an acute or a chronic care hospital ☐ Yes ☐ No

Section 2 – Devices and Eligibility (to be completed by Physician/Nurse Practitioner)

Devices Currently Required by the Applicant on an ongoing daily basis, Based on Eligibility Criteria for ADP Funding Assistance

Complete and submit the relevant Section(s) below:

(check one or more as appropriate)

☐ Continuous Positive Airway Pressure Systems (CPAPS) . . . Section 2a

☐ Bi-Level Positive Airway Pressure Systems (BPAPS) Section 2a

☐ Auto-titrating Positive Airway Pressure Systems (APAPS) . . Section 2a

This page must be completed and submitted