

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)

- |  |   |  |   |
|--|---|--|---|
| 1. Applicant is the sibling of a Sudden Infant Death Syndrome (SIDS) Infant.                         | <input checked="" 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 checked="" 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 checked="" type="checkbox"/> No | <input type="checkbox"/> N/A            |
| 4. Applicant has a Tracheostomy (purchase only).   | <input type="checkbox"/> Yes            | <input type="checkbox"/> No            | <input checked="" 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 | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | <input type="checkbox"/> N/A |
|--|------------------------------|--|------------------------------|