

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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Reason for Application (check one)

- ☐ First access for Mobility Devices
- ☐ Another type of device required in addition to Previously ADP Funded Device(s)
- ☐ Modifications to Non ADP Funded Device(s)
- ☐ Replacement of Previously ADP Funded Device(s) no longer in use
- ☐ Modifications/Adjustments /Additional Components to Previously ADP Funded Device(s) currently in use

Replacement Device(s) and/or Modifications Required Due To: (check as appropriate)

- ☐ Change in applicant's mobility status - previously ADP funded equipment no longer meeting basic mobility needs as defined by ADP for funding purposes
- ☐ Change in applicant's body size - previously ADP funded equipment is either too large or too small.
- ☐ Previously ADP funded equipment is worn out
- ☐ Special circumstances - none of the above - **attach letter of rationale.**

Confirmation of Applicant's Eligibility for a Positioning Devices – Seating (answer required for each statement)

1. Applicant requires the seating components to provide postural support and/or pressure relief during mobility. Applicant can maintain a functional posture during mobility with the seating components prescribed. ☐ Yes ☐ No ☐ N/A
2. Applicant requires the tray prescribed to provide postural support during mobility and/or to support an ADP approved communication aid required during mobility. ☐ Yes ☐ No ☐ N/A

Non ADP Funded Options Prescribed (Optional)

Set Up Instructions for Vendor (Optional)

☐ **Custom Modifications Required**

The authorizer must provide clinical rationale to support the request in the space below and attach a vendor quote that provides a breakdown of the cost of labour (not to exceed \$40.00/hour) and parts.