| Applicant's Last Name | First Name | Health Number (10 digits) | Version |
|---|---|---|---|
| | | | |

## Section 2b – Compressors

**Device (check one or more as appropriate)**

- [x] Medication Compressor - Portable
- [x] Medication Compressor - Stationary
- [ ] High Output Air Compressor

**Reason for Application (check one)**

- [x] 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
- [x] 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. | ☐ Yes | ☑ No | ☐ N/A |
| 2. | Applicant is receiving inhaled antibiotics. | ☐ Yes | ☑ No | ☐ N/A |
| 3. | Applicant has a physical disability that prevents them from using a powdered delivery or metered-dose form of medication. | ☐ Yes | ☐ No | ☑ N/A |
| 4. | Applicant has not yet developed the co-ordination required to operate powdered delivery or metered-dose devices. | ☑ Yes | ☐ No | ☐ N/A |
| 5. | Applicant has a permanent or long-term tracheostomy and requires high humidification of inspired air. | ☐ Yes | ☐ No | ☑ N/A |
| 6. | Applicant has a permanent tracheostomy and requires inhaled aerosolized antibiotics. | ☐ Yes | ☐ No | ☑ N/A |

## Section 2c – Suction Devices

**Device (check one or more as appropriate)**

- [ ] Stationary Suction Unit
- [x] Portable Suction Unit
- [ ] Suction Supplies

**Reason for Application (check one)**

- [x] 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. | ☐ Yes | ☑ No | ☐ N/A |
| 2. | Applicant requires a portable suction device. | ☐ Yes | ☐ No | ☑ N/A |