Ontario

Ministry of Health and Long-Term Care
Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Tel: 416 327-8804
1 800 268-6021
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Application for Funding Respiratory Equipment & Supplies

Clear Form

RE1

Section 1 – Applicant's Biographical Information

PLEASE PRINT

Last Name	First Name	Middle Initial

Health Number *(10 digits)*	Version	Date of Birth *(yyyy/mm/dd)*	Gender
		/ /	☐ Male ☐ Female

Name of Long-Term Care Home (LTCH) *(if applicable)*

Address

Building Number	Street Name	Suite/Apt Number

Lot/Concession/Rural Route	City/Town	Postal Code
	ON	

Home Telephone *(include area code)*	Business Telephone *(include area code)*	Ext
- -	- -	

Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If ***yes***, check ☒ one only:

☐ 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) – Group A ☐ Yes ☐ No

I am a resident of a Long-Term Care Home (LTCH) ☐ Yes ☐ No

I am a patient of 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

(check one or more as appropriate) *Complete and submit the relevant Section(s) below:*

☐ 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**
☐ Medication **Compressors**.....	**Section 2b**
☐ High Output Air **Compressors**	**Section 2b**
☐ **Suction Units**	**Section 2c**
☐ Apnea/Cardiorespiratory **Monitors**.....	**Section 2d**
☐ **Airway Clearance Devices**.....	**Section 2e**
☐ **Tracheostomy** Equipment	**Section 2f**

This page must be completed and submitted

  Disponible en Français

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

Section 2a – Positive Airway Pressure Systems *(to be completed by Physician)*

Device *(check one)*

☐ Continuous Positive Airway Pressure (CPAP)

☐ Auto-titrating Positive Airway Pressure (APAP)

☐ Bi-level Positive Airway Pressure (BPAP)

Reason for Application *(check one)*

☐ First access for Positive Airway Pressure Systems

☐ 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 Positive Airway Pressure System

For all Positive Airway Pressure System devices

1. Applicant has completed a Level 1 sleep study which confirms a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS) and has the presence of symptoms without therapy and the absence of symptoms with therapy. *(Clinic Number must be provided in Section 4)*	☐ Yes	☐ No	☐ N/A
2. Applicant has been provided by the Sleep Lab with a copy of the ADP Applicant *Respiratory Fact Sheet*	☐ Yes	☐ No	☐ N/A

For APAP devices:

3. Individual has a documented diagnosis of OSAS where there is a change in pressure of a minimum of 4 cmH_2O on a prescribed fixed CPAP level of 10 cmH_2O or more.	☐ Yes	☐ No	☐ N/A
4. The change in pressure occurs between REM vs. NREM or supine vs. non-supine.	☐ Yes	☐ No	☐ N/A

For BPAP devices:

5. Individual has a documented diagnosis of OSAS and despite CPAP of 15 cmH_2O or greater, exhibits one of the following: i) Nocturnal hypoxemia (O_2 saturation <88%) ii) Nocturnal hypercapnia ($PaCO_2$ >50mmHg) iii) Apnea/hypopnea index > 10	☐ Yes	☐ No	☐ N/A
6. Individual has a documented diagnosis of OSAS and CPAP of 15 cmH_2O or greater resolves the physiological abnormalities but the individual is unable to tolerate this pressure	☐ Yes	☐ No	☐ N/A
7. Individual has a documented diagnosis of OSAS but is either unable to tolerate any level of CPAP or continues to complain of excessive daytime sleepiness (EPWORTH score equal to or greater than 10)	☐ Yes	☐ No	☐ N/A

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

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.	☐ 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 ☐ 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.	☐ Yes	☐ No	☐ N/A
2. Applicant requires a portable suction device.	☐ Yes	☐ No	☐ N/A

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

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.	☐ Yes	☐ No	☐ N/A
2.	Applicant is an infant who has experienced an Apparent Life-Threatening Episode (ALTE).	☐ Yes	☐ No	☐ N/A
3.	Applicant is a premature infant in whom apnea persists beyond 37 weeks corrected gestational age.	☐ Yes	☐ No	☐ N/A
4.	Applicant has a Tracheostomy *(purchase only)*	☐ Yes	☐ No	☐ 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)*

1.	Applicant has cystic fibrosis	☐ Yes	☐ No	☐ 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)*

1.	Applicant has undergone a tracheostomy	☐ Yes	☐ No	☐ N/A

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

Section 3 – Client Consent and Signature

I consent to the Ministry of Health and Long-Term Care (the Ministry) collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive benefits under the Ministry's Assistive Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and Insurance Board (WSIB) collecting, using and disclosing personal information about me, including the information on this form and information related to my entitlement to health care benefits under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and verifying my eligibility to receive benefits under the Program and WSIA.

The Ministry and WSIB will limit the information that they exchange about me to only that information that is necessary for the purpose above.

The Ministry will only use and disclose my personal health information in accordance with the *Personal Health Information Protection Act, 2004*, and the Ministry's "Statement of Information Practices" which is accessible at: www.health.gov.on.ca**.** In addition, the WSIB will collect, use and disclose personal information about me from the Ministry for the purpose of administering and enforcing the WSIA**.**

I understand that if I choose to withhold or withdraw my consent to the collection, use and disclosure of this information by the Ministry or WSIB, I may be denied coverage under the Program.

For more information on the Ministry's Information Practices, or the collection, use or disclosure of the personal information on this form, call 1-800-268-6021/416-327-8804 or TTY: 416-327-4282 or write to the Program Manager, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5.

NOTE: **This section of the form may be signed only by the applicant or his or her agent**

I have read the Applicant Information Sheet, understand the rules of eligibility for ADP and am eligible for the equipment specified.

I certify that the information I have provided on this form is true, correct and complete to the best of my knowledge. I understand that this information is subject to audit.

Signature		Date *(yyyy/mm/dd)*
X	☐ Applicant ☐ Agent	/ /

If the above signature is not that of the applicant, specify relationship and complete contact information below

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Public Trustee ☐ Power of Attorney

PLEASE PRINT

Last Name	First Name	Middle Initial

Building Number	Street Name	Suite/Apt Number

Lot/Concession/Rural Route	City/Town	Province	Postal Code

Home Telephone *(include area code)*	Business Telephone *(include area code)*	Ext
- -	- -	

Section 4 – Signatures
Physician/Nurse Practitioner Signature

I hereby certify that I have personally assessed the applicant in person and determined that the applicant has a chronic respiratory illness or disability requiring the long-term use of the device(s) or supplies specified above.

☐ Physician / ☐ Nurse Practitioner

PLEASE PRINT

Physician/Nurse Practitioner's Last Name	Physician/Nurse Practitioner's First Name

Business Telephone *(include area code)*	Ext	Ontario Health Insurance Billing No *(6 digits)*
- -		

Physician/Nurse Practitioner's Signature	Date Signed *(yyyy/mm/dd)*
X	/ /

Clinic providing Sleep Lab diagnosis (for Positive Airway Pressure Systems applications only)

Clinic Name

ADP Clinic Number	Business Telephone *(include area code)*	Ext
	- -	

This page must be completed and submitted

Applicant's Last Name, First Name *(PLEASE PRINT)*	Health Number *(10 digits)*	Version

Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number

PLEASE PRINT

Vendor Representative's Last Name	Vendor Representative's First Name

Position Title	Business Telephone *(include area code)*	Ext
	- -	

Vendor Location

Vendor Representative's Signature	Date *(yyyy/mm/dd)*	Vendor Invoice Number
X	/ /	

Equipment Specifications

ADP Device Code	Description of Item *(Make & Model)*	Serial Number	ADP Portion	Client Portion
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

Proof of Delivery

I confirm that I have received the respiratory device(s) specified above and that I have received a fully itemized invoice from the vendor. I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

Signature	Date of Delivery *(yyyy/mm/dd)*
X	/ /

Pages and Attachments Being Submitted

1. **Complete this application form in full according to applicant's eligibility for ADP funding assistance and make a copy for your records.**
2. **Check the following pages/sections of the application form and the attachments that are included with your submission:**
   - ☒ Section 1 – Applicant's Biographical Information & Confirmation of Eligibility ***(Section 1 must be completed and submitted)***
   - ☐ Section 2a – Positive Airway Pressure Systems (PAPS)
   - ☐ Section 2b – Compressors
   - ☐ Section 2c – Suction Devices
   - ☐ Section 2d – Monitors
   - ☐ Section 2e – Airway Clearance Devices
   - ☐ Section 2f – Tracheostomy Equipment
   - ☒ Section 3 and Section 4 – Consent and Signatures ***(Sections 3 and 4 must be completed and submitted)***
3. **Attachments** ***(if required)*** ***Note: Other attachments will not be considered by the Assistive Devices Program***
   - ☐ Repair Quote - Replacement of ADP funded equipment due to normal wear and tear
4. **Application form may be submitted to ADP once all signatures are obtained – applicant/agent, physician/nurse practitioner and vendor.**

This page must be completed and submitted

Note: Attach vendor/manufacturer's quote and/or repair bills if required (see Section 2)

Other attachments will not be considered by the Assistive Devices Program

It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding for a device.