Ontario

Ministry of Children, Community and Social Services

Ontario Disability Support Program

Mandatory Special Necessities Benefit Application

The Ontario Disability Support Program's (ODSP) Mandatory Special Necessities benefit helps with the cost of diabetic supplies, surgical supplies and dressings, and items and devices required as a direct result of a surgical, radiological or medical procedure or disease. It also provides funding for medical-related travel to appointments, to local alcohol and drug recovery groups, and to mental health therapy and counselling programs. Approval is based on the most economical cost.

Applicant to complete the following information below.

Fields marked with an asterisk (*) are mandatory.

Applicant Information Requiring Items/Services to be Completed

Last Name

First Name	Middle Initial

Date of Birth (dd/mm/yyyy)	Member ID *	ODSP Office Address & Fax (internal purposes)

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Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Applicant Declaration and Consent for Release of Information

The application will not be approved if the declaration and consent for release of information is not signed.

The person applying for the Mandatory Special Necessities benefit, or someone lawfully authorized to sign on their behalf, must sign this declaration and consent for release of information.

If the Mandatory Special Necessities benefit is for a child under 16, then the declaration and consent for release of information must be signed by another individual who is lawfully authorized to sign on their behalf.

I declare that the information I have supplied and the information in this application is to the best of my knowledge and belief true, correct and complete. I consent to the release, by the health care professional who has completed this application, to the Ministry of Children, Community and Social Services ("ministry"), of any information in my health records relating to the information provided on this application form. I understand that the ministry would be using this information to determine my initial eligibility or ongoing eligibility for the Mandatory Special Necessities benefit.

I have read and signed this consent freely and voluntarily. I understand that I can refuse to sign the consent but that the Mandatory Special Necessities benefit will not be provided if the consent is not signed. I understand that I can revoke or amend the consent at any time but that this may affect my eligibility for the Mandatory Special Necessities benefit.

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Name of Applicant or Other Lawfully Authorized Individual (First and Last Name)	Signature	Date (dd/mm/yyyy)

Note: The Criminal Code of Canada s.s. 380 (1) provides that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence. The *Ontario Disability Support Program Act, 1997*, Sec. 59 states a person who knowingly receives a benefit or assistance that he/she is not entitled to receive under the Act and regulations is guilty of an offence.

Submitting the Completed Application Form

Please include vendor estimates/quotes for the items/devices, including medical travel being requested through this application if available.

The completed form can be submitted:

- Online through MyBenefits at www.Ontario.ca/MyBenefits
- Directly to the local ODSP office or;
- By mail: PO Box 3399 Stn Main, Markham ON L3R 6J2

Applicant Name (First and Last Name) _____

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Instructions for Health Care Professional

The Ontario Disability Support Program (ODSP) may assist with the costs of eligible medical transportation, diabetic supplies, surgical supplies and dressings, as well as items and devices.

Only complete the sections below that are applicable to your patient's documented medical needs. The ministry may request supporting information, including verification of attendance to determine eligibility.

Medical Transportation

ODSP covers the cost of the most affordable way for a client to travel to medical appointments. To be eligible your patient must be travelling to medical treatment provided by a health care professional, or to alcohol and drug recovery groups available locally, or to mental health therapy that has been prescribed by a physician or psychologist. The following health care professionals licensed to practice in Ontario can complete this section:

- Physicians
- Occupational Therapists
- Psychologists
- Physiotherapists
- Nurse Practitioners
- Physician Assistants
- Registered Nurses

The default mode of transportation is public transportation (e.g., buses, subway, trains and para-transit).

Applicant Name (First and Last Name) _____

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Based on your patient's medical condition can they use public transit or para-transit if it is available? Please check one.

- ☐ My patient does not have a medical condition that prevents them from using public transit where it is available
- ☐ My patient has a medical condition that prevents them from using public transit where it is available

If your patient cannot use public transit, do they require specialized patient transportation services?

☐ Yes ☐ No

Complete the table below with the following information, for transportation over the next 12 months.

Visit Location Health Care Professional's Name and/or Facility Name	Telephone Number (If known)	Visits over next 12 months	Required from (mm/yy)	Required until (mm/yy)	Is an attendant or overnight stay required?
		☐ Month ☐ Year Number of Visits _____			☐ Attendant ☐ Overnight

Applicant Name (First and Last Name) _____

Member ID _____

OHIP Fee Code KO54

Visit Location Health Care Professional's Name and/or Facility Name	Telephone Number (If known)	Visits over next 12 months	Required from (mm/yy)	Required until (mm/yy)	Is an attendant or overnight stay required?
		☐ Month ☐ Year Number of Visits _____			☐ Attendant ☐ Overnight
		☐ Month ☐ Year Number of Visits _____			☐ Attendant ☐ Overnight

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Visit Location Health Care Professional's Name and/or Facility Name	Telephone Number (If known)	Visits over next 12 months	Required from (mm/yy)	Required until (mm/yy)	Is an attendant or overnight stay required?
		☐ Month ☐ Year Number of Visits _____			☐ Attendant ☐ Overnight

Surgical Supplies, Items and Devices

ODSP helps with the costs of medical supplies, and items and devices not otherwise provided by any other provincial, federal or private program. The following health care professionals licensed in Ontario can complete this section:

- Physicians
- Occupational Therapists
- Registered Nurses
- Nurse Practitioners
- Physician Assistants
- Physiotherapists

For each applicable section, indicate if your patient has been diagnosed with a medical condition that requires surgical supplies, items or devices, and the expected duration of need. Attach if available, assessments and estimates for items being requested.

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Wound Care and Surgical Supplies

Is your patient diagnosed with a medical condition or undergoing medical treatment requiring surgical supplies? For example, antiseptic solutions, bandages, compression bandages, shields/sponges/gauze, irrigation supplies, or gloves.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Pressure Devices and Lymphedema Management Devices, Items and Supplies

Is your patient diagnosed with lymphedema requiring lymphedema management items and supplies? For example, compression bandages, compression stockings/sleeves/gloves, or padding.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Incontinence Products and Supplies

Is your patient diagnosed with a medical condition that requires incontinence products and supplies? For example, catheters, diapers and liners, under pads, incontinence supplies, gloves, or enema kits.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Diabetic Supplies

Is your patient diagnosed with diabetes that requires diabetic supplies? For example, tubing, lancets, needle tips, syringes, antiseptic wipes, or insulin pens.

☐ **Yes** ☐ **No** For gestational diabetes provide expected date of delivery (dd/mm/yyyy) _____

Applicant Name (First and Last Name) _____

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For the following tables, specify the item being requested, the expected duration of need and attach, if available, estimates/ quotes for items/devices being requested.

Self Care Related Aids, Accessories and Feeding

Is your patient diagnosed with a chronic medical condition that impacts their ability to attend to their personal care requiring assistive devices? For example, bathing, toileting/transfer aids, bed accessories, enteral feeding supplies, or protective aids.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Specify the Supply/Item/Device (or attach with form)

Limb Prosthetic Devices and Items

Does your patient need or rely on prosthetics devices and require items to support their prosthetic? For example, sleeves, liners, sheaths, socks, or prosthetics.

☐ **Yes** ☐ **No**

Specify the Supply/Item/Device (or attach with form)

Applicant Name (First and Last Name) _____

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Braces, Casts and Splint Devices

Is your patient diagnosed with a medical condition requiring a brace/ cast or splint to prevent surgery, for post-surgical care, to assist with physical healing or to improve physical functioning that has been impaired?

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Specify the Supply/Item/Device (or attach with form)

Respiratory Related Devices

Is your patient diagnosed with sleep apnea, a chronic respiratory illness or has a tracheostomy requiring related supplies? For example, positive airway pressure supplies, suction and tracheostomy supplies, or compressors.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Specify the Supply/Item/Device (or attach with form)

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Monitoring and Medical Devices

Is your patient diagnosed with a medical condition that requires monitoring and medical devices? For example, fall-related alarms for high-risk patients, TENS device and supplies, blood pressure monitor, or other devices.

☐ **Yes** ☐ **No**

Duration ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite

Specify the Supply/Item/Device (or attach with form)

Health Care Professional's Signature and Information

I confirm that the information I have provided is true in my professional opinion.

Name of Health Care Professional (First and Last Name)	Signature	Date (dd/mm/yyyy)

Note: The Criminal Code of Canada s.s. 380 (1) provides that everyone who by deceit, falsehood or other fraudulent means defrauds the public of any property, money or valuable security, is guilty of an offence. The *Ontario Disability Support Program Act, 1997*, Sec. 59 states a person who knowingly receives a benefit or assistance that he/she is not entitled to receive under the Act and regulations is guilty of an offence.

Applicant Name (First and Last Name) _____

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Please complete below with your information

I, _____
Last Name, First Name

am a legally qualified _____ in the Province of Ontario;
Profession

and registered with _____
Professional Regulatory College

My registration number is _____
Registration Number

Office Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Telephone Number	Extension	Fax Number

Office Email

Or

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

Office Stamp

Billing Information for Completion of this Form

Physicians directly bill the Ontario Health Insurance Plan (OHIP) using OHIP fee code KO54.

Nurse Practitioners, Registered Nurses, Physician Assistants, Occupational Therapists, Physiotherapists and Psychologists submit your invoice for $25 and include the following information:

Payee information: First and last name, profession, regulatory college and registration number.
Mailing address, telephone number, email address.

Applicant information: First and last name, member ID

Service Rendered: Payment of completion of MSN Application

Send invoice to: PO Box 3399 Stn Main
Markham, ON
L3R 6J2

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*, Sections 5, 10, 45 and 46 for the purpose of administering the Ontario Disability Support Program.

Applicant Name (First and Last Name) _____

Member ID _____ **OHIP Fee Code KO54**

For more information contact _____

at _____, in your local office.

Save Form **Print Form**