

Assistive Devices Program (ADP)  
5700 Yonge Street, 7th Floor  
Toronto ON M2M 4K5  
Tel: 416-327-8804  
Toll-Free: 1-800-268-6021  
TTY: 416-327-4282  
TTY: 1-800-387-5559

Fields marked with an asterisk (\*) are mandatory.

**Section 1 – Applicant’s Biographical Information**

Last Name *		
First Name *		Middle Initial
Health Number (10 digits)	Version	Date of Birth (yyyy/mm/dd)
Name of Long-Term Care Home (LTCH) (if applicable)		
<b>Address</b>		
Unit Number		Street Number
Street Name *		
Lot/Concession/Rural Route *		
City/Town *	Province *	Postal Code *
	ON	
Home Telephone Number	Business Telephone Number ext.	

**Confirmation of Benefits**

I am receiving social assistance benefits  Yes  No  
 If yes, please check one  Ontario Works Program (OWP)  
 Ontario Disability Support Program (ODSP)  
 Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Mobility Devices from:  
 Workplace Safety & Insurance Board (WSIB)  Yes  No  
 Veterans Affairs Canada (VAC) – Group A  Yes  No

**Section 2 – Devices and Eligibility (to be completed by Authorizer)**

Applicant’s presenting medical condition - **Must Be Completed**

Applicant’s basic functional mobility status related to the need for an ADP funded device - **Must Be Completed**

**This page must be completed and submitted**

Applicant's Last Name	First Name	Health Number (10 digits)	Version
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**Mobility Equipment Previously Funded by ADP (check one or more as appropriate)**

- |                               |  |  |   |
|-------------------------------|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Forearm crutches  | <input type="checkbox"/> Power add on device           | <input type="checkbox"/> Power recline system                   |
|                               | <input type="checkbox"/> Wheeled walker    | <input type="checkbox"/> Power scooter                 | <input type="checkbox"/> Power elevating leg rests              |
|                               | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Positioning devices (seating) | <input type="checkbox"/> Paediatric standing frame              |
|                               | <input type="checkbox"/> Power wheelchair  | <input type="checkbox"/> Power tilt system             | <input type="checkbox"/> Paediatric specific specialty stroller |

**Device(s) Currently Required by the Applicant on an ongoing daily basis, Based on Eligibility Criteria for ADP Funding Assistance**

Complete and submit the relevant Section(s) below:

(check one or more as appropriate)

- Forearm crutches only to achieve independent mobility . . . . . **Section 2a**
- A wheeled walker only to achieve independent mobility . . . . . **Section 2a**
- A manual wheelchair only to achieve independent mobility . . . . . **Section 2b**
- An ambulation aid and a manual wheelchair to achieve independent mobility. . . . . **Section 2a and Section 2b**
- A manual wheelchair to achieve mobility (dependent for propulsion) . . . . . **Section 2b**
- A manual dynamic tilt wheelchair to achieve independent mobility. . . . . **Section 2b**
- A manual dynamic tilt wheelchair to achieve mobility (dependent for propulsion) . . . . . **Section 2b**
- A manual wheelchair with a power add-on device to achieve independent mobility. . . . . **Section 2b**
- A power base only to achieve independent mobility . . . . . **Section 2c**
- A power scooter only to achieve independent mobility . . . . . **Section 2c**
- An ambulation aid and a power base/scooter to achieve independent mobility . . . . . **Section 2a and Section 2c**
- Positioning devices (seating) for a wheelchair - modular and/or custom fabricated . . . . . **Section 2d**
- A high technology power base (dynamic tilt and/or recline and/or power elevating leg rests)  
– **attach justification for funding chart**. . . . . **Section 2c**
- A paediatric standing frame . . . . . **Section 2a**
- Modifications to previously ADP funded device(s). . . . . **Section 2a/ambulation aid,  
Section 2b/manual  
wheelchair, Section 2c/power  
wheelchair**
- Modifications to non ADP funded device(s) . . . . . **Section 2a/ambulation aid,  
Section 2b/manual  
wheelchair, Section 2c/power  
wheelchair**

**This page must be completed and submitted**

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## Section 2a – Ambulation Aids

### Base Device (check one walker and/or forearm crutches and/or one paediatric standing frame)

- Adult Wheeled Walker Type 1   
 Paediatric Specific Wheeled Walker Type 1   
 Paediatric Standing Frame Type 1  
 Adult Wheeled Walker Type 2   
 Paediatric Specific Wheeled Walker Type 2   
 Paediatric Standing Frame Type 2  
 Adult Wheeled Walker Type 3   
 Paediatric Specific Wheeled Walker Walking Frame   
 Forearm Crutches  
 None

### 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  
**- attach vendor quote and/or copies of repair bills for wheeled walkers and wheelchairs only.**  
 Special circumstances - none of the above - **attach letter of rationale.**

### Confirmation of Applicant's Eligibility for Ambulation Aids (answer required for each statement)

- |  |                              |                             |                              |
|--|------------------------------|-----------------------------|------------------------------|
| 1. Applicant requires the prescribed device in order to move throughout his/her place of residence.                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2. Applicant requires the prescribed device in order to move beyond his/her place of residence.                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 3. Applicant requires the prescribed device to access wheelchair inaccessible areas in his/her place of residence. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 4. Applicant is independently mobile with the prescribed device.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 5. Applicant requires forearm crutches.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 6. Applicant requires a paediatric specific standing frame.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

**Section 2a continued**

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**Prescription Details for Wheeled Walker Only: (answers required for all specifications)**

1. Seat Height \_\_\_\_\_  cm or  inches  N/A
2. Push Handle Height \_\_\_\_\_  cm or  inches
3. Hand Grips  None  Standard  Anatomical  
Forearm Attachments  One  Two
4. Width Between Push Handles \_\_\_\_\_  cm or  inches
5. Client Weight \_\_\_\_\_  kg or  lbs
6. Brakes  None  Push -To-Lock  Auto Stop
7. Brake Type  None  Bilateral  One Hand
8. Number of Wheels  Two  Three  Four
9. Wheel Size  4-6 inches  6-8 inches  8-10 inches
10. Back Support  Yes  No

**Additional ADP Funded Options Required for Prescribed Device (if applicable check one or more)**

- Adolescent Size Paediatric Specific Wheeled Walker
- Adolescent Size Paediatric Wheeled Walker – Walking Frame
- Adolescent Size Paediatric Standing Frame

**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.

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### Section 3 – Applicant's Consent and Signature

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

I consent to the Ministry of Health (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](http://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.

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	<input type="checkbox"/> Applicant * <input type="checkbox"/> Agent *	Date (yyyy/mm/dd)
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**If the above signature is not that of the applicant, specify relationship to applicant and fill out contact information**

Spouse  
  Parent  
  Legal Guardian  
  Public Trustee  
  Power of Attorney

Last Name
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First Name	Middle Initial
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<b>Address</b> Unit Number	Street Number
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Street Name
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Lot/Concession/Rural Route
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City/Town
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Province ON	Postal Code
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Home Telephone Number	Business Telephone Number	ext.
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### Section 4 – Signatures

#### Authorizer's Signature

I hereby certify that I have personally assessed the applicant named on this form in person, I have confirmed his/her eligibility for funding assistance in accordance with all ADP funding guidelines, I have authorized the equipment described on this form based on a comprehensive clinical assessment, and have taken all safety and environmental concerns into consideration. I have advised the applicant or his/her agent that (i) he/she may purchase the ADP approved equipment from the ADP Registered Vendor of their choice, and have provided a list of ADP Registered Vendors in the applicant's community for their use or (ii) have informed the applicant or his/her agent about the policies and procedures of the ADP Central Equipment Pool for High Technology Wheelchairs (CEP).

Authorizer's Last Name	Authorizer's First Name
Business Telephone Number ext.	ADP Authorizer Registration Number
Authorizer's Signature	Assessment Date (yyyy/mm/dd)

#### Vendor/Vendor Representative Information

1. Vendor Business Name	ADP Vendor Registration Number
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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 Representative (Last Name, First Name)	Position Title
Vendor Location	Business Telephone Number ext.
Vendor Representative's Signature	Date Signed (yyyy/mm/dd)

2. Vendor Business Name	ADP Vendor Registration Number
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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 Representative (Last Name, First Name)	Position Title
Vendor Location	Business Telephone Number ext.
Vendor Representative's Signature	Date Signed (yyyy/mm/dd)

#### Equipment Specifications (Ambulation Aids Only)

Vendor Invoice Number	Vendor's ADP Registration Number	Base Device
ADP Device Code (Base Device)	Description of Item (Make & Model)	ADP Portion
Serial Number		Client Portion

#### Proof of Delivery

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

Signature	<input type="checkbox"/> Applicant <input type="checkbox"/> Agent	Date of Delivery (yyyy/mm/dd)
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**Pages and Attachments Being Submitted**

**Note to ADP Registered Authorizer:**

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 – Ambulation Aids
  - Section 2b – Manual Wheelchairs
  - Section 2c – Power Bases and Power Scooters
  - Section 2d – Positioning Devices (Seating) for Mobility
  - 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**
  - Vendor Quote - Replacement of ADP funded equipment due to normal wear and tear
  - Vendor Quote - Custom Modifications to ADP Listed Device
  - Justification for Funding Chart - Dynamic Positioning Device (power tilt and/or recline and/or power elevating leg rests)
  - Letter of Rationale - Extenuating Circumstances Only
4. **Application form may be submitted to ADP once all signatures are obtained – applicant/agent, authorizer and vendor(s).**

**This page must be completed and submitted**

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