Ontario

Ministry of Health and Long-Term Care

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Application for Funding Mobility Devices Page 1

To print, use the [Print Form] button at the bottom of the last page.

Clear Form

Section 1 - Applicant's Biographical Information & Confirmation of Eligibility

PLEASE PRINT

Last name	First name	Middle initial

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

Address Building number	Street name	Type *(St/Blvd/ Ave/Dr/Cr)*	Direction *(N/S/W/E)*	Suite/apt. number

Lot/concession/rural route	City/Town	Postal code
	ON	

Health number (10 digits)	Version	Date of birth *(dd/mm/yyyy)*	Sex
		/ /	☐ male ☐ female

Home telephone *(include area code)*	Business telephone *(include area code)*	Ext.
( ) -	( ) -	

Confirmation of Eligibility

Applicant's medical diagnosis/condition MUST BE COMPLETED

Applicant's basic functional mobility status related to the need for an ADP funded device - MUST BE COMPLETED

Mobility Equipment Previously Funded by ADP *(check one or more as appropriate)*

- ☐ forearm crutches
- ☐ wheeled walker
- ☐ manual wheelchair
- ☐ power wheelchair
- ☐ power add on device
- ☐ power scooter
- ☐ positioning devices (seating)
- ☐ power tilt system
- ☐ power recline system
- ☐ power elevating leg rests
- ☐ paediatric standing frame
- ☐ paediatric specific specialty stroller
- ☐ none

Reason for Application *(check one or more as appropriate)*

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

This page must be completed and submitted

Applicant's Last name, First name *(PLEASE PRINT)*	Health number *(10 digits)*	Version

Replacement Device(s) and/or Modifications Required Due To: ***(check one or more 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.**

Device(s) 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 page(s) below:***
☐ Forearm crutches only to achieve independent mobility……..	**page 2**
☐ Wheeled walker only to achieve independent mobility…….	**page 2**
☐ A manual wheelchair only to achieve independent mobility…….	**page 3**
☐ An ambulation aid and a manual wheelchair to achieve……. independent mobility	**page 2 and page 3**
☐ A manual wheelchair to achieve mobility (dependent for propulsion)……..	**page 3**
☐ A manual dynamic tilt wheelchair to achieve independent mobility……..	**page 3**
☐ A manual dynamic tilt wheelchair to achieve mobility…….. (dependent for propulsion)	**page 3**
☐ A manual wheelchair with a power add-on device to achieve……. independent mobility	**page 3**
☐ A power wheelchair only to achieve independent mobility……..	**page 4**
☐ A power scooter only to achieve independent mobility…….	**page 4**
☐ An ambulation aid and a power wheelchair/scooter to achieve……. independent mobility	**page 2 and page 4**
☐ Positioning devices (seating) for a wheelchair - modular and/or custom….. fabricated	**page 5**
☐ A high technology power wheelchair (dynamic tilt and/or recline and/or….. power elevating leg rests) – ***attach justification for funding chart***	**page 4 and/or page 5**
☐ A paediatric standing frame……..	**page 2**
☐ Modifications to previously ADP funded device(s)…….	**page 2/ambulation aid, page 3/manual wheelchair, page 4/power wheelchair**
☐ Modifications to non ADP funded device(s)……..	**page 2/ambulation aid, page 3/manual wheelchair, page 4/power wheelchair**

This page must be completed and submitted

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Applicant's Last name, First name *(PLEASE PRINT)*	Health number *(10 digits)*	Version
ADP Registered Authorizer's Last name, First name *(PLEASE PRINT)*		

Section 2 - Ambulation Aids

Confirmation of Applicant's Eligibility For A Wheeled Walker *(answer required to all statements (1 - 6)*

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

Base Device & ADP Device Code *(check one walker and/or forearm crutches and/or one paediatric standing frame)*

- ☐ MW1 Adult Wheeled Walker
- ☐ MW2 Adult Wheeled Walker
- ☐ MW3 Adult Wheeled Walker
- ☐ MW4 Paediatric Specific Wheeled Walker
- ☐ MW5 Paediatric Specific Wheeled Walker
- ☐ MW6 Paediatric Specific Walking Frame
- ☐ MKZ Forearm Crutches
- ☐ MS1 Paediatric Standing Frame
- ☐ MS2 Paediatric Standing Frame

Prescription for Wheeled Walker only *(answer required for all specifications 1-10)*

1. Seat Height: _____	☐ N/A					
2. Push Handle Height: _____						
3. Hand Grips	☐ None	☐ Standard	☐ Anatomical	☐ Forearm Attachments	☐ One	☐ Two
4. Width Between Push Handles Exceeds 19"	☐ No	☐ Yes *(specify width)*: _____				
5. Client Weight Exceeds 275 lbs	☐ No	☐ Yes *(specify client weight)*: _____				
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"	☐ 6"-8"	☐ 8"-10"			
10. Back Support	☐ yes	☐ no				
11. ☐ Other ADP funded option *(future ADP use)*: _____						

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Applicant's Last name, First name *(PLEASE PRINT)*	Health number *(10 digits)*	Version

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

- ☐ Adolescent Size Paediatric Specific Walker
- ☐ Adolescent Size Paediatric Walking Frame
- ☐ Adolescent Size Paediatric Standing Frame

Non ADP Funded Options Prescribed *(Optional)*

Set Up Instructions for Vendor *(Optional)*

Custom Modifications Required (MOCM) *(answer required)* ☐ **Yes** ☐ **No**

Request may be submitted when custom modifications are required to an ADP listed ambulation aid or paediatric standing frame, and there is no ADP code with assigned funding available. 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.

For ADP Use Only

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ADP Registered Authorizer's Last name, First name *(PLEASE PRINT)*		

Section 3 - Manual Wheelchairs

Confirmation of Applicant's Eligibility For A Manual Wheelchair *(answer required to all statements (1-13)*

1.	Applicant requires the use of a manual wheelchair to move throughout his/her place of residence and can move independently throughout his/her place of residence with the prescribed device.	☐ Yes	☐ No	☐ N/A
2.	Applicant requires the use of a manual wheelchair to move beyond his/her place of residence and can move independently beyond his/her place of residence with the prescribed device.	☐ Yes	☐ No	☐ N/A
3.	Applicant requires the use of a manual wheelchair to move throughout his/her place of residence and is dependent on attendant for propulsion.	☐ Yes	☐ No	☐ N/A
4.	Applicant requires the use of a manual wheelchair to move beyond his/her place of residence and is dependent on attendant for propulsion.	☐ Yes	☐ No	☐ N/A
5.	Applicant requires the use of a titanium frame wheelchair to move independently throughout his/her place of residence.	☐ Yes	☐ No	☐ N/A
6.	Applicant requires the use of a titanium frame wheelchair to move independently beyond his/her place of residence.	☐ Yes	☐ No	☐ N/A
7.	Applicant can weight shift independently in the sitting position.	☐ Yes	☐ No	☐ N/A
8.	Applicant demonstrates a history of tissue trauma and/or a significant risk of tissue trauma when sitting and skin integrity cannot be maintained with the addition of fixed seating alone.	☐ Yes	☐ No	☐ N/A
9.	Applicant cannot maintain a functional posture in sitting due to abnormal tone and/or joint contractures and posture cannot be supported with the addition of fixed seating alone.	☐ Yes	☐ No	☐ N/A
10.	Applicant demonstrates an intolerance for sitting which cannot be increased for mobility with the addition of fixed seating alone.	☐ Yes	☐ No	☐ N/A
11.	Applicant is able to propel a manual wheelchair independently but requires some daily use of power to move throughout his/her place of residence.	☐ Yes	☐ No	☐ N/A
12.	Applicant is able to propel a manual wheelchair independently but requires some daily use of power to move beyond his/her place of residence.	☐ Yes	☐ No	☐ N/A
13.	It is anticipated that the applicant will be able to use a manual wheelchair with a power add-on device for his/her long-term mobility needs and will not require the use of a power wheelchair/power base within the designated funding period.	☐ Yes	☐ No	☐ N/A

Base Device & ADP Device Code *(check one)*

- ☐ WMA1 Adult Standard Manual Wheelchair
- ☐ WMA2 Adult Lightweight Standard Manual Wheelchair
- ☐ WMA3 Adult Lightweight Performance Manual Wheelchair
- ☐ WMA4 Adult High Performance Rigid Manual Wheelchair
- ☐ WMA5 Adult Manual Dynamic Tilt Wheelchair
- ☐ WMK2 Paediatric Lightweight Standard Manual Wheelchair
- ☐ WMK3 Paediatric Lightweight Performance Manual Wheelchair
- ☐ WMK4 Paediatric High Performance Rigid Manual Wheelchair
- ☐ WMK5 Paediatric Manual Dynamic Tilt Wheelchair
- ☐ WMK6 Paediatric Specific Specialty Stroller
- ☐ WPS1 Power Add-On Device Requested *(check in addition to base device if required)*.

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Applicant's Last name, First name *(PLEASE PRINT)*	Health number *(10 digits)*	Version

Prescription Details For Manual Wheelchair *(answer required for all specifications)*

1. Seat Width, *(specify):* _____	2. Seat Depth, *(specify):* _____
3. Finished Seat to Floor Height, *(specify):* _____	4. Back Cane Height, *(specify):* _____
5. Finished Back Height, *(specify):* _____	6. Finished Leg Rest Length, *(specify):* _____

7. Client Weight, *(specify):* _____

NOTE: The ADP approved price includes frame sizes up to 18"wide x 18"deep, standard upholstery, swing away detachable footrests, height adjustable armrests, rear anti-tippers, 2 point seat belt any closure, brake extensions, front casters and standard solid or pneumatic wheels. See product manual for details about all generic device types.

Additional ADP Funded Options Required for Prescribed Manual Wheelchair *(check one or more)*

- ☐ Heavy Duty Cross Braces & Upholstery
- ☐ Adjustable Tension Back Upholstery
- ☐ Recliner Option
- ☐ Angle Adjustable Footplates *(pair)*
- ☐ Elevating Legrests *(pair)*
- ☐ One Arm/Lever Drive
- ☐ HUB-EEZ Easy Push Wheel
- ☐ Uni-Lateral Wheel Lock
- ☐ Plastic Coated Handrims
- ☐ Spoke Protectors *(pair)*
- ☐ Projected Handrims *(pair)*
- ☐ Standard Manual Wheelchair Frame with Manual Dynamic Tilt *****
- ☐ Grade Aids *(pair)*
- ☐ Caster Pin Locks (pair)
- ☐ Amputee Axle Plates (pair)
- ☐ Quick Release Axles *(pair)*
- ☐ Clothing Guards *(pair)*
- ☐ Stroller Handles/Paediatric
- ☐ Oxygen Tank Holder
- ☐ Ventilator Tray
- ☐ Titanium Frame *****
- ☐ TERRATREK UPGRADE
- ☐ LEVO MANUAL UPGRADE
- ☐ Other ADP funded option *(future ADP use)* _____

*** *Provide Clinical Rationale***

Non ADP Funded Options Prescribed *(Optional)*

Set Up Instructions for Vendor *(Optional)*

Custom Modifications Required (WCM2) *(answer required)* ☐ **Yes** ☐ **No**

Request may be submitted when custom modifications are required to a manual wheelchair and there is no ADP code with assigned funding available. 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 4 - Power Wheelchairs & Power Bases & Power Scooters

Confirmation of Applicant's Eligibility For A Power Wheelchair or Power Base
(answer required to statements 1 and 2)

1. Applicant requires the use of a power wheelchair/power base to move independently throughout his/her place of residence.	☐ Yes	☐ No	☐ N/A
2. Applicant requires the use of a power wheelchair/power base to move independently beyond his/her place of residence.	☐ Yes	☐ No	☐ N/A

Confirmation of Applicant's Eligibility For A Power Scooter
(answer required to all statements (1 – 3)

1. Applicant requires the use of a power device to move independently throughout his/her place of residence.	☐ Yes	☐ No	☐ N/A
2. Applicant requires the use of a power device to move independently beyond his/her place of residence.	☐ Yes	☐ No	☐ N/A
3. Applicant operates the prescribed device independently with the standard scooter seat and tiller.	☐ Yes	☐ No	☐ N/A

Base Device & ADP Device Code (*check one)*

☐ WPA1 Adult Power Wheelchair	☐ WPK1 Paediatric Power Wheelchair
☐ WPA2 Adult Power Wheelchair	☐ WPK2 Paediatric Power Wheelchair
☐ WPA3 Adult Power Base	☐ WPK3 Paediatric Power Base
☐ WS1 Power Scooter	☐ WPK4 Paediatric Power Wheelchair with Manual Dynamic Tilt

Prescription Details for Power Device
(answer required for all specifications 1-6 for power wheelchair or power base and 6 only for power scooters)

1. Seat Width, *(specify):* _____
2. Finished Back Height, *(specify):* _____
3. Finished Seat to Floor Height, *(specify):* _____
4. Leg Rest Length, *(specify):* _____
5. Seat Depth, *(specify):* _____
6. Client Weight, *(specify):* _____

NOTE: The ADP approved price includes seat and back frame sizes up to 18"wide x 18"deep, standard joystick control, upholstery, swingaway detachable footrests, height adjustable armrests, 2 point seat belt any closure, front casters and standard solid or pneumatic wheels. See product manual for details about all generic device types.

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Applicant's Last name, First name *(PLEASE PRINT)*	Health number *(10 digits)*	Version

Additional ADP Funded Options Required for Prescribed Power Wheelchair or Power Base *(check one or more)*

- ☐ Midline Control
- ☐ Adjustable Tension Back Upholstery
- ☐ Manual Recline Option
- ☐ Angle Adjustable Footplates *(pair)*
- ☐ Manual Elevating Legrests *(pair)*
- ☐ One Piece 90/90 Front Riggings
- ☐ Swingaway Mounting Bracket
- ☐ Seat Package 1 for Power Bases (includes frame, sling upholstery, armrests, footrests)
- ☐ Seat Package 2 for Power Bases (includes deluxe seat and back, armrests, footrests)
- ☐ Oxygen Tank Holder
- ☐ Ventilator Tray
- ☐ LEVO POWER UPGRADE
- ☐ Other ADP funded option *(future ADP use)* _____

Provide clinical rationale for the following Specialty Components in space below*

- ☐ Specialty Controls 1 Non Standard Joystick*
- ☐ Specialty Controls 2 Chin/Rim Control*
- ☐ Specialty Controls 3 Simple Touch*
- ☐ Specialty Controls 4 Proximity Control*
- ☐ Specialty Controls 5 Breath Control*
- ☐ Specialty Controls 6 Scanners*
- ☐ Auto Correction System*

**** Provide clinical rationale***

Non ADP Funded Options Prescribed *(Optional)*

Set Up Instructions for Vendor *(Optional)*

Custom Modifications Required (WCM2) *(answer required)* ☐ **Yes** ☐ **No**

Request may be submitted when custom modifications are required to an ADP listed power wheelchair/base and there is no ADP code with assigned funding available. 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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ADP Registered Authorizer's Last name, First name *(PLEASE PRINT)*

Section 5 - Positioning Devices *(Seating)* for Mobility

Confirmation of Applicant's Eligibility For Positioning Devices (Seating)
(answer required to statements 1 and 2)

1. Applicant requires the following 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

Product Specific Prescription

Description	Quantity *(specify number)*	ADP Catalogue Number
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E
		S E

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See Product Manual Section 5, Positioning for Mobility (Seating) for devices that require clinical rationale*.

**** Provide clinical rationale***

Non ADP Funded Options Prescribed *(Optional)*

Set Up Instructions for Vendor *(Optional)*

Insert ADP Device Code **SEMND2005** in the prescription table above when custom modifications are required to an ADP listed **modular seating device** and there is no ADP code with assigned funding available. 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 6 – Confirmation of Eligibility and Signatures

Applicant Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

*If **yes**, check one only:*

☐ Ontario Works (OW) ☐ Ontario Disability Support Program (ODSP)

☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible for:

Workplace Safety & Insurance Board (WSIB) Coverage for the same disability ☐ Yes ☐ No

Veterans' Affairs Canada (VAC) Group A Pension for the same disability ☐ Yes ☐ No

Consent / Authorization

The Ministry of Health and Long-Term Care's (the Ministry) collection of the personal health information on or attached to this form is necessary for the purpose of assessing and verifying eligibility for the Assistive Devices Program, and for all other purposes related to the proper administration of that Program.

This information may be used or disclosed in accordance with the *Personal Health Information Protection Act*, 2004, as set out in the Ministry's "Statement of Information Practices" which is accessible at: **www.health.gov.on.ca** .

Applicants may withhold their consent to the collection of this information; however, doing so will interfere with their coverage under the Assistive Devices Program.

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

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

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 ☐ Applicant ☐ Agent	Date *(dd/mm/yyyy)* / /
Name of Witness, as necessary *(print first name, then last name)*	Signature of Witness

If signature is not that of the applicant, specify relationship of the signer to applicant and fill out contact information

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

PLEASE PRINT

Last name	First name	Middle initial

Address Building number	Street name	Type *(St/Blvd/ Ave/Dr/Crt)*	Direction *(N/S/W/E)*	Suite/apt. number

Lot/concession/rural route	City/Town	Province	Postal code

Home telephone *(include area code)*	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

Authorizer's Signature and Confirmation of Applicant's Eligibility

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 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).

PLEASE PRINT

Authorizer's Last Name	First Name

Business Telephone *(include area code)*	ADP Authorizer No.
( ) - Ext.	
Authorizer's Signature	Authorizer's Assessment Date *(dd/mm/yyyy)*
	/ /

Vendor/Vendor Representative Information

PLEASE PRINT

1. Vendor Business Name	ADP Registration No.

I hereby certify that the equipment as prescribed has been provided or will be provided to the applicant

Vendor/Vendor Representative *(First name, Last name)*	Position	
Vendor/Vendor Representative Signature	Date *(dd/mm/yyyy)* / /	Business Telephone *(include area code)* ( ) - Ext.

2. Vendor Business Name	ADP Registration No.

I hereby certify that the equipment as prescribed has been provided or will be provided to the applicant

Vendor/Vendor Representative *(First name, Last name)*	Position	
Vendor/Vendor Representative Signature	Date *(dd/mm/yyyy)* / /	Business Telephone *(include area code)* ( ) - Ext.

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 of the application form **and** the attachments that are included with your submission:
   - ☒ Page 1 - Applicant's Biographical Information & Confirmation of Eligibility ***(page 1 must be completed and submitted)***
   - ☐ Page 2 - Ambulation Aids
   - ☐ Page 3 - Manual Wheelchairs
   - ☐ Page 4 - Power Wheelchairs & Power Bases & Power Scooters
   - ☐ Page 5 - Positioning Devices *(Seating)* for Mobility
   - ☒ Page 6 - Confirmation of Eligibility and Signatures ***(page 6 must be completed and submitted)***
3. **Attachments *(check one or more)***
   - ☐ Vendor Quote - Replacement of ADP funded equipment due to normal wear and tear
   - ☐ Vendor Quote - Modifications to ADP Listed Ambulation Aid *(MOCM)*
   - ☐ Vendor Quote - Modifications to ADP Listed Manual Wheelchair Frame *(WCM2)*
   - ☐ Vendor Quote - Modifications to ADP Listed Power Wheelchair/Base Frame *(WCM2)*
   - ☐ Vendor Quote - Modifications to ADP Listed Positioning Device/Seating *(SEMND2005)*
   - ☐ 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

Print Form