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Ontario

Ministry of Health and Long-Term Care

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

Application for Funding Insulin Pumps and Supplies for Adults

Section 1 – Biographical Information

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		Postal Code
		ON	

Health Number	Version Code	Date of Birth *(dd/mm/yyyy)*	Sex
		/ /	☐ Male ☐ Female

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

Section 2 – Confirmation of Eligibility for Insulin Pump Therapy

To be completed by an Endocrinologist or another Specialist Physician associated with an adult diabetes program. This information is based on adult diabetes team's pre-assessment according to ADP requirements.

In order to confirm eligibility for ADP funding assistance the applicant/caregiver must agree to ALL of the following criteria:

Applicant has type 1 diabetes	☐ Yes
Applicant has demonstrated experience with a basal/bolus insulin regimen for at least one year *(not mandatory if applying for Insulin Pump Supplies only)*	☐ Yes
Applicant has participated in a pre-assessment for insulin pump therapy according to ADP Requirements	☐ Yes
Applicant demonstrates the ability to self-assess and take action based on blood glucose results by: Carbohydrate counting, correction bolus & sick day management	☐ Yes
Applicant demonstrates a commitment to long-term diabetes follow-up through regular assessments by diabetes educators and physicians at least 3 times a year or as deemed appropriate by the diabetes team	☐ Yes

Number of episodes of DKA in last 12 months _____	Number of severe episodes of hypoglycaemia in last 12 months _____

Provide the last two A1c results

1. Date *(dd/mm/yyyy)*	A1c	2. Date *(dd/mm/yyyy)*	A1c
/ /		/ /	

Date insulin pump therapy 90 day trial initiated	Indicate make and model of the insulin pump prescribed	
Date *(dd/mm/yyyy)*	Make	Model
/ /		

I certify that the above named person has type 1 diabetes and demonstrated a clinical need for insulin pump therapy and is participating in a diabetes education program.

Physician's Signature	**Last name, First name *(please print)***	Date *(dd/mm/yyyy)*	OHIP Billing Number
		/ /	

Name and Address of Diabetes Program/Team Providing Education

Program/Team Name	ADP Clinic Number

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		Postal Code	Business Telephone *(include area code)*	
	ON			Ext.

Section 3 – Equipment Request & Specifications

Check one box only:

☐ **Insulin Pump and Supplies, *(Section 3 must be completed by insulin pump vendor)***

☐ **Insulin Supplies Only *(complete Section 5)***
– *(Applicant must keep copies of receipts for 2 years after the purchase date)*

☐ **Replacement Insulin Pump *(Section 3 must be completed by insulin pump vendor)***

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

Vendor Name	ADP Registration Number

I hereby certify that the equipment as prescribed has been provided to the applicant.

Vendor Representative

Last Name	First Name	Invoice Number

Vendor's Representative Signature	Date (dd/mm/yyyy)	Business Telephone *(include area code)*
	/ /	Ext.

Section 4 – Proof of Delivery and Confirmation of Participation in a 90 day Trial Period

To be completed and signed by the applicant or agent

I confirm that I have received the insulin pump described in Section 3 and that I agree to participate in a 90 day trial. If at the end of the 90 day trial period, if it is determined that I am not a suitable candidate for insulin pump therapy at this time, I agree to return the Insulin pump to the vendor indicated in Section 3. On receipt of the returned insulin pump the vendor must credit the ADP the full amount of the ADP price in order to ensure that I may reapply at a future date.

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

Section 5 – Consent/Authorization

Consent/Authorization

The Ministry of Health and Long-Term Care's (the Ministry) collection of the personal health information on this form is necessary for the purposes 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 only be signed by the applicant or 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. I understand that I must keep copies of my receipts for insulin pump supplies for 2 years after the purchase date.

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

If signature above is not that of the applicant, complete the payee information below. Copy of legal documents must be enclosed

PLEASE PRINT

Name of Payee

Last Name	First Name	Middle Initial

Address of Payee

Building Number	Street Name	Type *(St./Blvd./ Ave./Dr./Crt.)*	Direction *(N/S/W/E)*	Suite/Apt. Number

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

Signature	Home Telephone *(include area code)*	Date *(dd/mm/yyyy)*
		/ /

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