

Ministry of Health and Long-Term Care

Assistive Devices Program

Application for Limb Prosthesis Funding Assistance

Facsimiles or photocopies of this application are not accepted. Please PRINT clearly. Claim no.

Plate imprint

It is an offence to knowingly provide false information on the application. Collection of information on this form is authorized under the Ministry of Health Act, RSO 1990, c.M.26, Section 6(1) to determine eligibility for assistance under the Assistive Devices Program. For further details concerning this collection, please contact the Manager, Registration and Claims at the Assistive Devices Program, 5700 Yonge Street, 7th floor, Toronto ON M2M 4K5, telephone no. (416) 327–8804, toll free 1–800–268–6021, T.T.Y. 1–800–387–5559, fax no. (416) 327–8192. Section 1: Applicant Information (to be completed by applicant or agent) Date of birth (dd/mm/yyyy) Last name of applicant (print) Initials Sex M Address Apt. no. City, town or village Postal code Area code Telephone no. Health no. I am receiving social assistance benefits. yes no Ontario Works (OW) Ontario Disability Support Program (ODSP) If yes, check one only: Assistance to Children with Severe Disabilities (ACSD) I have applied previously to ADP for a limb prosthesis. ves no yes I require the limb prosthesis because of a motor vehicle accident. no I am eligible for Ontario Health Insurance coverage and I have a valid health card number issued in my name. no I am eligible to receive funding for a limb prosthesis through the Department of Veterans Affairs "Group A" insurance. ves no I am eligible to receive funding for a limb prosthesis through the Workers' Compensation Board. yes no I have read and understand the program Limb Prosthesis Fact Sheet. I consent to the collection and disclosure of medical and non-medical information by the Assistive Devices Branch (ADB) to the Workplace Safety & Insurance Board (WSIB), and by the WSIB to the ADB, to determine my eligibility to receive funding assistance from the ADB. I certify that the above information is true, correct and complete to the best of my knowledge. I authorize the release of information collected on this application by the Ministry of Health to its agents, the ADP registered vendor indicated on this form, my insurance company and any other third party that the Ministry may need to consult with to verify eligibility for ADP funding. Note: This form may be signed only by the applicant or an agent who represents the applicant and cannot be an authorizer or vendor of the prosthesis. Signature of applicant or agent Date (dd/mm/yyyy) Correspondence to be sent to: Applicant Agent If the signature above is **not** that of the applicant, print the signee's information below: Last name of agent Area code Telephone no. Apt no. Address City/Town/Village Province Postal code Section 2: Diagnosis (to be completed by the Amputee Team Physician) I certify that the above named person has a chronic physical disability and requires the regular use of these prosthetic items due to one of the following reasons (Please write "R" for right, "L" for left, "B" for bilateral in only one appropriate box.) 2a Partial foot 2f Trans-femoral 2k Trans-radial 2p Other (specify) 2h Ankle disarticulation 2g Hip disarticulation 21 Elbow disarticulation 2c Trans-tibial 2h Trans-pelvis Trans-humeral 2i 2d Van Nes procedure Partial hand 2n Shoulder disarticulation 2e Knee disarticulation 2j Wrist disarticulation 20 Forequarter Type of amputation (Check either yes or no beside each category of reason for amputation) Yes No Congenital condition Acquired amputation (If yes, specify cause) Type of surgery: Date of surgery (dd/mm/yyyy) Name of physician (print) Prescription date (dd/mm/yyyy)

Cette publication, intitulée demande d'aide financière pour membre artificiel en français est disponsible auprès du DAAF au 1 800 268–1154.

Health insurance billing no.

Signature

Area code Telephone no.

Applicant name Claim no CL							App Fun	olication for Lin	nb Prosthesis ce – page 2		
Secti	on 3:	Limb Prosthesis Required (to be		ted by	the Certified Pr	osthetist)		.ug / 100101u	puge _		
Initial				Rea Writ	son for replacement e replacement reason	code (4a. etc	.) in colu	mn beside each line	item. if applicable.		
3a Preparatory prosthesis					4a Outgrown prosthesis or socket						
3b Definitive prosthesis					Residual limb atrophy						
Replacement Device 3c Replacement preparatory socket					c Worn out not due to client negligence						
3d Replacement definitive prosthesis				4d	Higher level of ampu	tation (write da	ate of su	rgery in section 2)			
3e Replacement definitive socket				4e	4e Change in medical condition, minor surgery (write date of surgery in section 2) (specify):						
3f Replacement components					(Specify).						
30	ı Mod	lifications/adjustments									
		Precise description of each prosth	etic item		ADF)		Unit cost	Total cost		
Repl. Reason	Side	(brand and model no.)			cat. n		Qty.	(\$)	(\$)		
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Ministry of Health and Long-Term Care

Assistive Devices Program

Application for Limb Prosthesis Funding Assistance

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Claim no.

CL

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Health insurance billing no.

Signature

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Applicant name Claim no CL					Application for Limb Prosthesis Funding Assistance – page 2						
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