Ontario

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.
It is an offence to knowingly provide false information on the application.

Plate imprint

Claim no.

CL

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)*

Last name of applicant *(print)* | First name | Initials | Date of birth *(dd/mm/yyyy)* | Sex ☐ M ☐ F

Apt. no. | Address

City, town or village | Postal code | Area code Telephone no. | Health no. | Version

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 have applied previously to ADP for a limb prosthesis. ☐ yes ☐ no

I require the limb prosthesis because of a motor vehicle accident. ☐ yes ☐ no

I am eligible for Ontario Health Insurance coverage and I have a valid health card number issued in my name. ☐ yes ☐ no

I am eligible to receive funding for a limb prosthesis through the Department of Veterans Affairs "Group A" insurance. ☐ yes ☐ 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. ☐ yes ☐ no

- * *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 | First name | Area code Telephone no.

Address | Apt no.

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)*
☐ 2b	Ankle disarticulation	☐ 2g	Hip disarticulation	☐ 2l	Elbow disarticulation	.....	
☐ 2c	Trans-tibial	☐ 2h	Trans-pelvis	☐ 2m	Trans-humeral	.....	
☐ 2d	Van Nes procedure	☐ 2i	Partial hand	☐ 2n	Shoulder disarticulation		
☐ 2e	Knee disarticulation	☐ 2j	Wrist disarticulation	☐ 2o	Forequarter		

Type of amputation (*Check either **yes** or **no** beside each category of reason for amputation)*

2q Congenital condition ☐ Yes ☐ No

2r Acquired amputation ☐ Yes ☐ No

(If yes, *specify cause)* .....

Type of surgery: | Date of surgery *(dd/mm/yyyy)*

Name of physician *(print)* | Prescription date *(dd/mm/yyyy)*

Signature | Health insurance billing no. | Area code Telephone no.

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

Section 3: Limb Prosthesis Required *(to be completed by the Certified Prosthetist)*

Initial device

- ☐ 3a Preparatory prosthesis
- ☐ 3b Definitive prosthesis

Replacement Device

- ☐ 3c Replacement preparatory socket
- ☐ 3d Replacement definitive prosthesis
- ☐ 3e Replacement definitive socket
- ☐ 3f Replacement components
- ☐ 3g Modifications/adjustments

Reason for replacement
Write replacement reason code (4a, etc.) in column beside each line item, if applicable.

- 4a Outgrown prosthesis or socket
- 4b Residual limb atrophy
- 4c Worn out not due to client negligence
- 4d Higher level of amputation (write date of surgery in section 2)
- 4e Change in medical condition, minor surgery (write date of surgery in section 2) (*specify) :*

.....

Repl. Reason	Side	Precise description of each prosthetic item (brand and model no.)	ADP cat. no.	Qty.	Unit cost ($)	Total cost ($)
					Total	
					ADP portion	

Note:
*For replacement of components or the entire limb prosthesis before the minimum replacement period, please complete a **Request for Special Approval for Limb Prosthetics**. Refer to ADP Administration Manuals for further details.*

☐ Check box if a **Request for Special Approval for Orthotics and Prosthetics** is attached.

ADP approval no.

I hereby certify that I have personally assessed the applicant, determined that the applicant meets ADP eligibility criteria, and that I authorize the equipment described on this form.

Last name of ADP Registered Limb Prosthesis Authorizer | First name | Signature

ADP authorizer reg. no. | ADP amputee team or EPULP clinic reg. no. | Area code Telephone no. | Date *(dd/mm/yyyy)*

Section 4: Rehabilitation Assessment *(to be completed by Team OT or PT)*

I certify that I, or _____ *(name of the therapist)* conducted a rehabilitation assessment of the applicant named on this form. Indicate the OT or PT college registration number for the assessor, if not registered with ADP:

Alternate therapist's COTO or CPO registration no.

I anticipate that the applicant could use the artificial limb for a range of daily activities within the ADP eligibility guidelines. ☐ Yes ☐ No

Last name of ADP Registered Rehabilitation Assessor | First name | Signature

ADP Rehabilitation Assessor no. | Area code Telephone no. | Assessment date *(dd/mm/yyyy)*

Section 5: Vendor Information *(to be completed by ADP-registered Limb Prosthesis Vendor)*

I hereby certify that the information on this form is true, correct and complete to the best of my knowledge and that the limb prosthesis has been provided to the above person.

Name of vendor | Signature | Date *(dd/mm/yyyy)*

Address | Vendor registration no. | Area code Telephone no.

Fax no.

To Vendor: *Please provide a copy of this application to the **applicant or agent** and retain a copy for your records.*

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Last name of ADP Registered Rehabilitation Assessor	First name	Signature

ADP Rehabilitation Assessor no.	Area code Telephone no.	Assessment date *(dd/mm/yyyy)*

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[redacted]

[redacted]