Assistive Devices Program Medical Professional Training

Completing the Application for Funding Ventilator Equipment & Supplies

June 2017

Ontario

Introduction

This training module will provide you with a step-by-step guide to completing the ADP ventilator equipment and supplies funding application form accurately.

For specific information about eligibility criteria, see the Grants Policy and Administration Manual.

Physicians are encouraged to provide employees/hospital staff with the information in this training module.

Training Outline

Assessment and Application Process

Rejected/Denied Application

Application Delays

Section 1:

- Applicant's Biographical Information & Confirmation of Benefits

Section 2:

- Devices and Diagnosis (to be completed by Physician)

Section 3:

- Applicant/Agent Consent and Signature

Section 4:

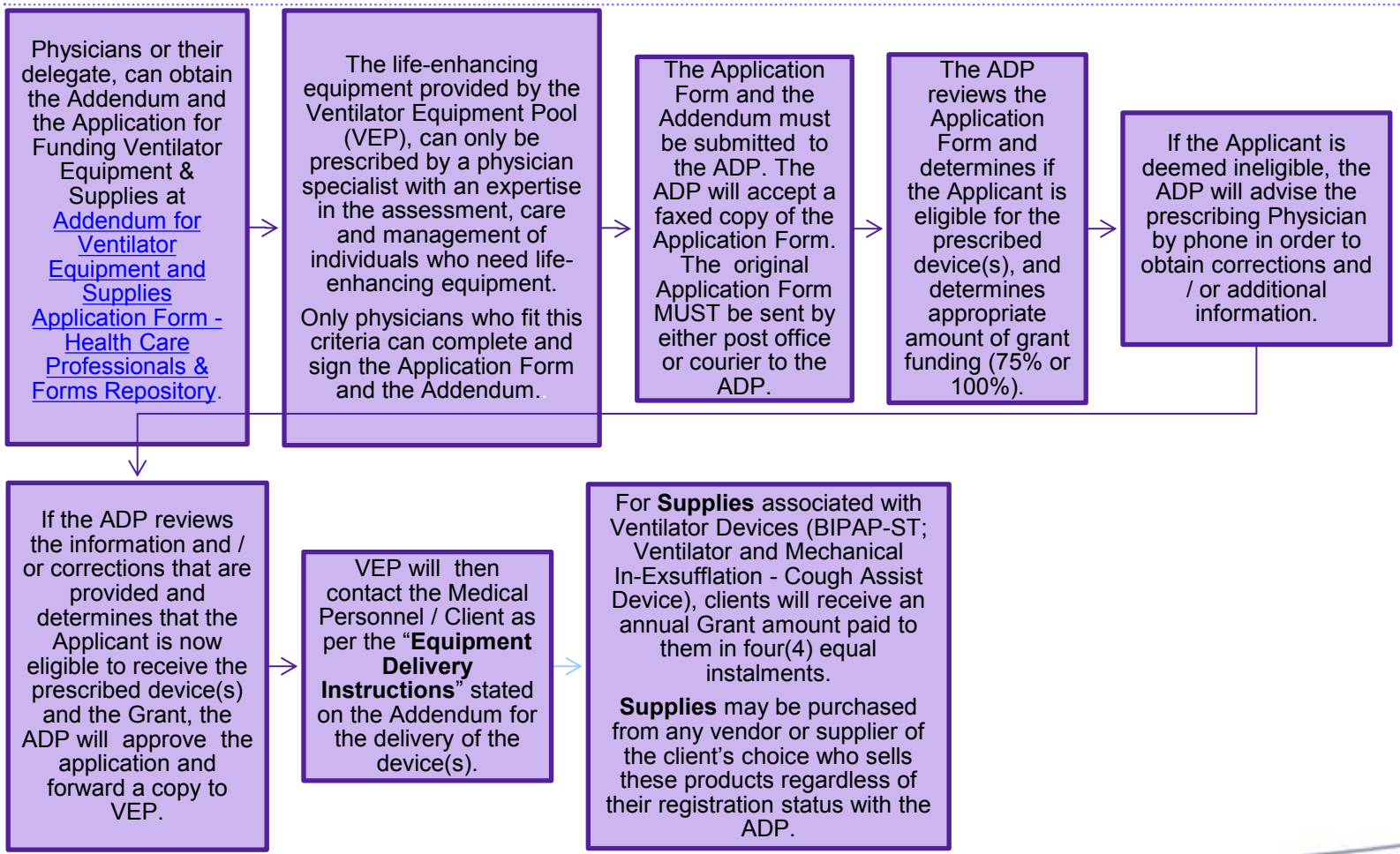
- Signatures - Physician's Signature

Submitting the Application Form

Additional Resources

Program Information

Assessment and Application Process



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Rejected/Denied Applications

An Applicant will be deemed ineligible if:

- They do not meet the ADP's medical eligibility criteria
- The Application Form is incomplete
- The Application From contains inaccurate information such as invalid Health Card number
- The Physician does not sign and date the Addendum

Application Delays

Getting Applications Approved

- Applications that are complete, accurate and submitted for individuals who are eligible as found in the ADP's Grants Policy and Administration Manual will be approved for funding.
- Correction fluid/tape MUST not be used on any part of the application. These applications will not be processed.

Mistakes and Omissions Result in Delays

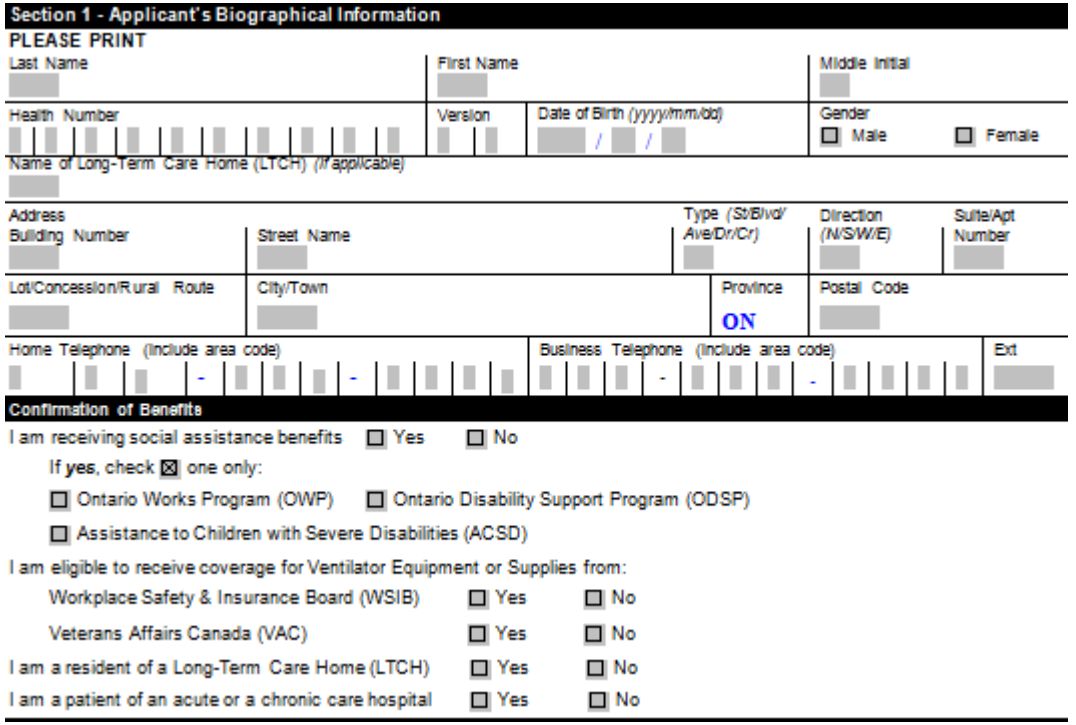
- Applications that are incomplete, inaccurate or are submitted for individuals who are ineligible for program funding will not be approved.
- Applications submitted without the Addendum will not be approved.

Section 1: Applicant's Biographical Information and Confirmation of Benefits

Health card information must be verified using the physical card.

The applicant's biographical information must match the information on the Health card, e.g. legal name and date of birth. Incorrect health card number will impact the application approval and processing time, and may result in the request being denied.

Applicants eligible for funding through WSIB or VAC Group A are not eligible for funding through the program. Physicians must not submit an application for these individuals.



Section 1 - Applicant's Biographical Information

PLEASE PRINT

Last Name | First Name | Middle Initial

Health Number | Version | Date of Birth (yyyy/mm/dd) | Gender ☐ Male ☐ Female

Name of Long-Term Care Home (LTCH) (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 | Province ON | Postal Code

Home Telephone (include area code) | Business Telephone (include area code) | Ext

Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If **yes**, check ☒ one only:

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

☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Ventilator Equipment or Supplies from:

Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No

Veterans Affairs Canada (VAC) ☐ Yes ☐ No

I am a resident of a Long-Term Care Home (LTCH) ☐ Yes ☐ No

I am a patient of an acute or a chronic care hospital ☐ Yes ☐ No

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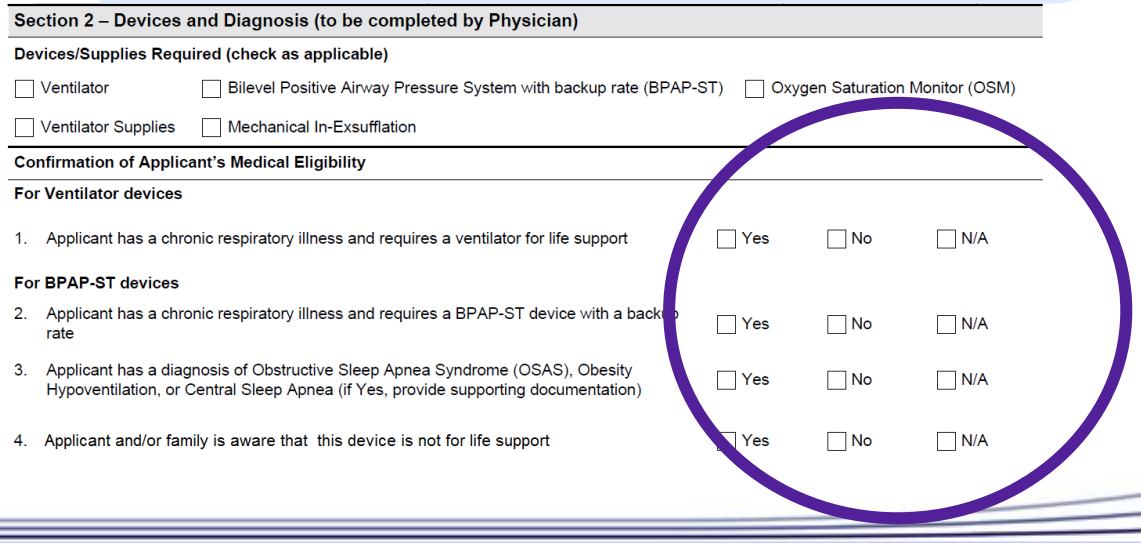
Section 2: Devices and Diagnosis

Physicians are required to verify the following information:

- The correct device(s) and if supplies is associated with the prescribed device(s) are selected
- Applicant meets the medical eligibility criteria for the prescribed device:
  - Ventilator
  - BPAP-ST
  - Oxygen Saturation Monitor
  - Mechanical In-Exsufflation



Section 2 – Devices and Diagnosis (to be completed by Physician)

Devices/Supplies Required (check as applicable)

☐ Ventilator ☐ Bilevel Positive Airway Pressure System with backup rate (BPAP-ST) ☐ Oxygen Saturation Monitor (OSM)

☐ Ventilator Supplies ☐ Mechanical In-Exsufflation

Confirmation of Applicant's Medical Eligibility

For Ventilator devices

1.	Applicant has a chronic respiratory illness and requires a ventilator for life support	☐ Yes	☐ No	☐ N/A

For BPAP-ST devices

2.	Applicant has a chronic respiratory illness and requires a BPAP-ST device with a backup rate	☐ Yes	☐ No	☐ N/A
3.	Applicant has a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS), Obesity Hypoventilation, or Central Sleep Apnea (if Yes, provide supporting documentation)	☐ Yes	☐ No	☐ N/A
4.	Applicant and/or family is aware that this device is not for life support	☐ Yes	☐ No	☐ N/A

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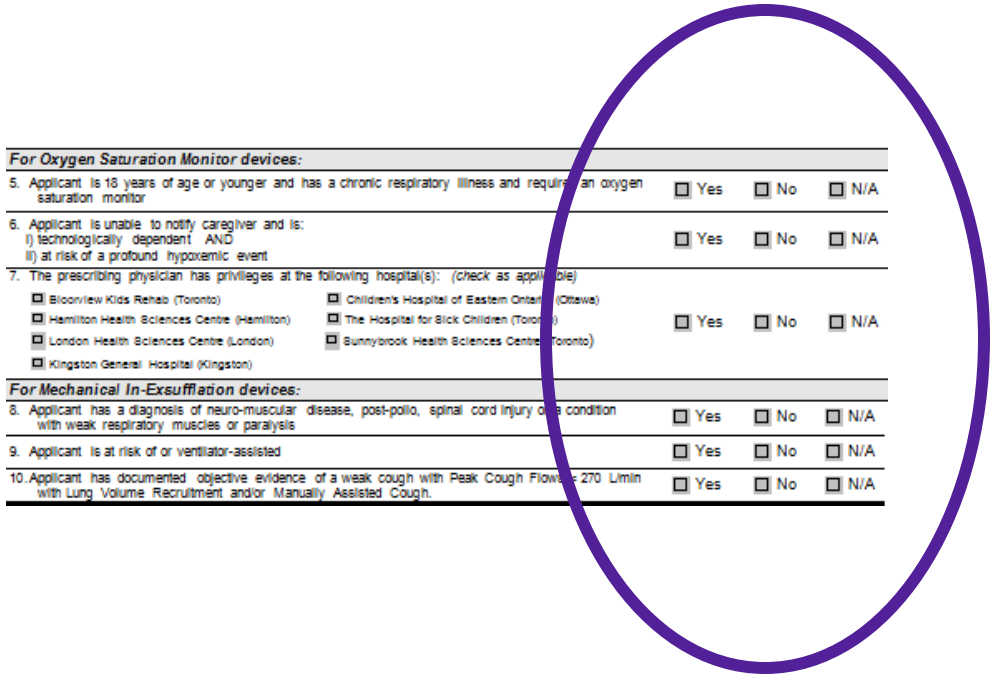
Section 2: Confirmation of Applicant's Eligibility

The physician **MUST** answer all the questions in Section 2 related to the device(s) being prescribed by checking the appropriate box with either Yes, No or N/A.



For Oxygen Saturation Monitor devices:

5. Applicant is 18 years of age or younger and has a chronic respiratory illness and requires an oxygen saturation monitor — ☐ Yes ☐ No ☐ N/A

6. Applicant is unable to notify caregiver and is:
   i) technologically dependent AND
   ii) at risk of a profound hypoxemic event — ☐ Yes ☐ No ☐ N/A

7. The prescribing physician has privileges at the following hospital(s): *(check as applicable)* — ☐ Yes ☐ No ☐ N/A
   - ☐ Bloorview Kids Rehab (Toronto)
   - ☐ Children's Hospital of Eastern Ontario (Ottawa)
   - ☐ Hamilton Health Sciences Centre (Hamilton)
   - ☐ The Hospital for Sick Children (Toronto)
   - ☐ London Health Sciences Centre (London)
   - ☐ Sunnybrook Health Sciences Centre (Toronto)
   - ☐ Kingston General Hospital (Kingston)

For Mechanical In-Exsufflation devices:

8. Applicant has a diagnosis of neuro-muscular disease, post-polio, spinal cord injury or a condition with weak respiratory muscles or paralysis — ☐ Yes ☐ No ☐ N/A

9. Applicant is at risk of or ventilator-assisted — ☐ Yes ☐ No ☐ N/A

10. Applicant has documented objective evidence of a weak cough with Peak Cough Flow ≤ 270 L/min with Lung Volume Recruitment and/or Manually Assisted Cough. — ☐ Yes ☐ No ☐ N/A

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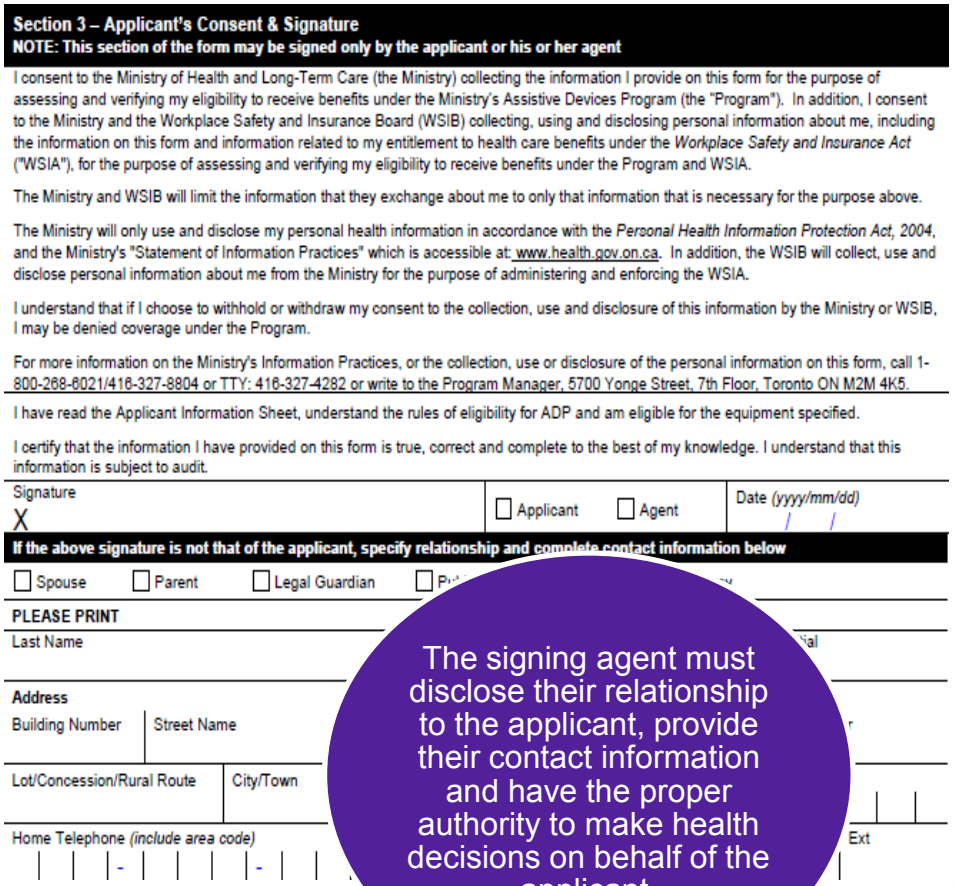
Section 3 – Applicant/Agent's Consent and Signature

The applicant/agent must read the consent statement before signing. Their signature confirms that they have read and understood this section (Section 3) of the application form.

Signatures must be original and made in ink. Exceptions required due to a disability will be handled on a case-by-case basis.



Section 3 – Applicant's Consent & 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 and Long-Term Care (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. 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 X | ☐ Applicant ☐ Agent | Date *(yyyy/mm/dd)*

If the above signature is not that of the applicant, specify relationship and complete contact information below

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ P…

PLEASE PRINT

Last Name … Initial

Address

Building Number | Street Name … Apt

Lot/Concession/Rural Route | City/Town … Postal Code

Home Telephone *(include area code)* - - … Ext

The signing agent must disclose their relationship to the applicant, provide their contact information and have the proper authority to make health decisions on behalf of the applicant.

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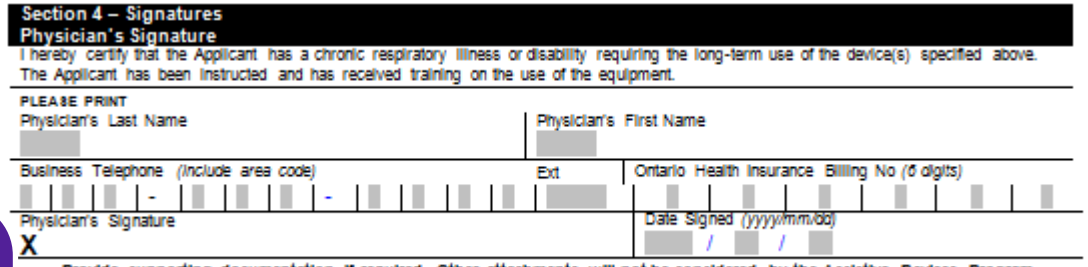
Section 4 - Signatures

The physician's **6-digit OHIP billing** is required for application processing.

Signatures must be original and made in ink.



Section 4 – Signatures
Physician's Signature

I hereby certify that the Applicant has a chronic respiratory illness or disability requiring the long-term use of the device(s) specified above. The Applicant has been instructed and has received training on the use of the equipment.

PLEASE PRINT

Physician's Last Name | Physician's First Name

Business Telephone *(include area code)* | Ext | Ontario Health Insurance Billing No *(6 digits)*

Physician's Signature | Date Signed *(yyyy/mm/dd)*

X

Provide supporting documentation if required. Other attachments will not be considered by the Assistive Devices Program.

NOTE: Resident doctors with temporary billing numbers, are not allowed to sign the form.

Provide supporting documentation ONLY IF required.

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Submitting the Application Form

Application and Addendum should be faxed to the ADP at (416) 327-8192 to expedite the application process.

Original application and Addendum signed in ink MUST be sent to the ADP by mail or courier.

Physician's office/hospital MUST retain a copy of the original application form and the Addendum for their records.

Verify that all sections have been completed accurately prior to submitting.

Submitted application forms that are incomplete, or are incorrectly completed, will not be approved and/or will be subjected to processing delays.

Additional Resources

- **Policies and Procedures Manual for the ADP**
- **Grants Policy and Administration Manual**
- Forms Repository

  Addendum for Ventilator Equipment and Supplies Application Form – Health Care Professionals

Program Information

ADP Website: http://www.health.gov.on.ca/adp

Mailing Address

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

Contacts:

Email: adp@ontario.ca
Program Coordinator: Mina Gousy
Telephone: (416) 212-8506
1 (800) 268-6021
Fax: (416) 327-8291 or
(416) 327- 8963

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