ADP Vendor Training

VISUAL AIDS:

Completing the Application for Optical Aids

April 2019

Ontario

Introduction

This training module will provide you with a step-by-step guide to completing the ADP visual aids application for optical aids.

For specific information relating to eligibility criteria, see the Visual Aids Policy and Administration Manual.

This training module is designed to:

- Provide a step-by-step guide to completing the Application for Funding Visual Aids accurately.

Vendors are encouraged to provide business associates and employees with the information in this training module.

Training Outline

Application Processing

Section 1

- Applicant's Biographical Information
- Confirmation of Benefits

Section 2

- Devices And Eligibility
- Reason for Application
- Replacement Visual Aid(s) Required Due To

Section 3 - Applicant's Consent & Signature

Section 4 - Signatures

- Prescriber's Signature (if applicable)
- Authorizer's Signature and Confirmation of Applicant's Eligibility
- Vendor Information

Submitting the Application Form

Application Processing

Program Information

Application Processing

Getting Applications Approved

- Applications that are complete, accurate and submitted for individuals who are eligible as found in the ADP's policy and administration manuals 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

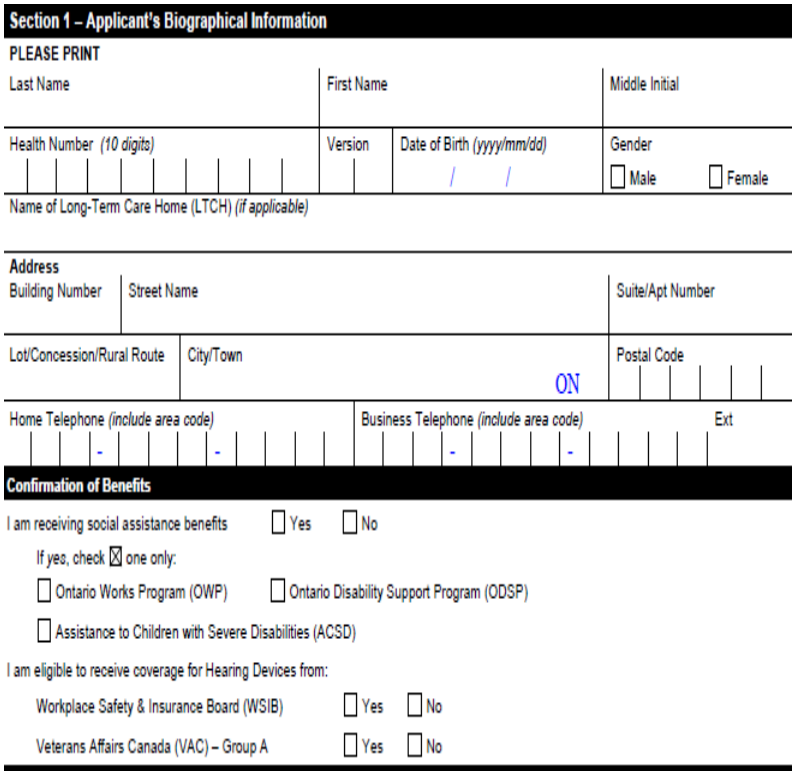
- Applications that are not complete, not accurate or are submitted for individuals who are ineligible for program funding will be returned and notification sent to the vendor via the Application Status Report.

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 numbers and other health card information will impact the application approval and processing time, and may result in the application being denied.

Applicants eligible for visual aids funding through WSIB or VAC Group A are not eligible for funding through the program, and must not submit an application



Section 1 – Applicant's Biographical Information

PLEASE PRINT

Last Name | First Name | Middle Initial

Health Number *(10 digits)* | Version | Date of Birth *(yyyy/mm/dd)* | Gender ☐ Male ☐ Female

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

Address

Building Number | Street Name | Suite/Apt Number

Lot/Concession/Rural Route | City/Town 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 Hearing Devices from:

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

Veterans Affairs Canada (VAC) – Group A ☐ Yes ☐ No

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Section 2 - Devices and Eligibility

Verify that the correct Optical Aids Device Type and Quantity is selected. This selection must correspond with the Device Code in Visual Aids Product Manual – Optical Aids section

The quantity for each device must not exceed 3.

Devices with exclusions to limit totals (marked with asterisk) are: Monocular stands and accessories, Spectacle mounted low vision accessories and Frames. They also must not exceed quantity 3 for each.

Applicant's Last Name	First Name	Health Number (10 digits)	Version

Section 2 – Devices and Eligibility (to be completed by Authorizer)

Functional Vision Status (check one)

☐ Sight Enhancement (low vision) ☐ Sight Substitution (no functional vision)

Devices/Supplies Required (check as appropriate)

Optical Aids	Quantity	Optical Aids	Quantity
☐ Magnifier		☐ Custom spec mount low vision aids	
☐ Illuminated Magnifier		☐ Field enhancement visual aid	
☐ Monocular		☐ Binocular	
☐ Monocular Stands and accessories*		☐ Specialized lenses	
☐ Spectacle-mounted low vision aids		☐ Frames for Low Vision Aids*	
☐ Spec mount low vision accessories*		☐ Contact lenses	

*Devices with exclusions to limit totals

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Section 2 – Reason For Application

Reason for Application (check one)

- ☐ First access to ADP for Visual Aid(s) category
- ☐ Another type of device required in addition to Previously ADP Funded Visual Aid(s)
- ☐ Replacement of Visual Aid(s)

Authorizers must check only one box applicable in this section, otherwise application will be automatically rejected.

Once you checked “Replacement of Visual Aid(s)” box, you MUST proceed to “Replacement Visual Aid(s) Required Due To” box

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Section 2 – Replacement Device(s) Due To

Replacement Visual Aid(s) Required Due To (check one)

- ☐ Change in medical condition
- ☐ Physical Growth / Atrophy
- ☐ Normal wear and applicant confirms that it is no longer under warranty

Authorizers must only check ONE box applicable in this section

In case of Change in Medical Condition or Physical Growth/Atrophy all supporting documentation (e.g., eye report) must be kept on file. ADP reserves right to request copy at any time.

In case “Normal wear” box is checked before the end of the designated funding period, the vendor must submit a quotation showing estimated cost of repair ad/or copies of repair bills.

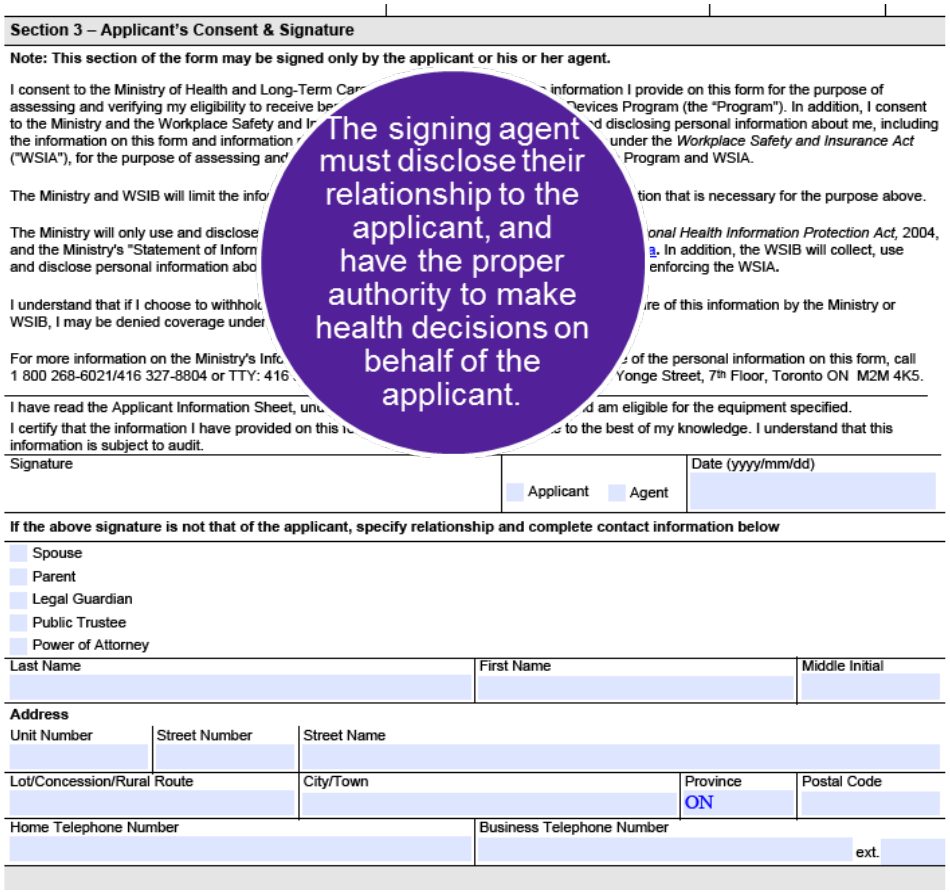
Section 3 – Applicant's Consent & Signature

The applicant must read the consent statement before signing.

The applicant must understand that signing the Consent and Signature Section confirms they have read the Applicant Information Sheet, understands the rules of eligibility and believes they are eligible.

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

When an agent is signing the application on behalf of an applicant, they are required to complete all information in Section 3.



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 Car… information I provide on this form for the purpose of assessing and verifying my eligibility to receive be… Devices Program (the "Program"). In addition, I consent to the Ministry and the Workplace Safety and In… disclosing personal information about me, including the information on this form and information … under the *Workplace Safety and Insurance Act* ("WSIA"), for the purpose of assessing and… Program and WSIA.

The Ministry and WSIB will limit the info… tion that is necessary for the purpose above.

The Ministry will only use and disclose … *onal Health Information Protection Act*, 2004, and the Ministry's "Statement of Inform… a. In addition, the WSIB will collect, use and disclose personal information abo… enforcing the WSIA.

I understand that if I choose to withhol… re of this information by the Ministry or WSIB, I may be denied coverage under …

For more information on the Ministry's Info… of the personal information on this form, call 1 800 268-6021/416 327-8804 or TTY: 416 … Yonge Street, 7th Floor, Toronto ON M2M 4K5.

I have read the Applicant Information Sheet, und… d am eligible for the equipment specified.

I certify that the information I have provided on this f… to the best of my knowledge. I understand that this information is subject to audit.

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

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

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

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route	**City/Town**	**Province**	**Postal Code**	
		ON		
Home Telephone Number	**Business Telephone Number**			
		ext.		

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

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Section 4 – Signatures: Prescriber and Authorizer Information

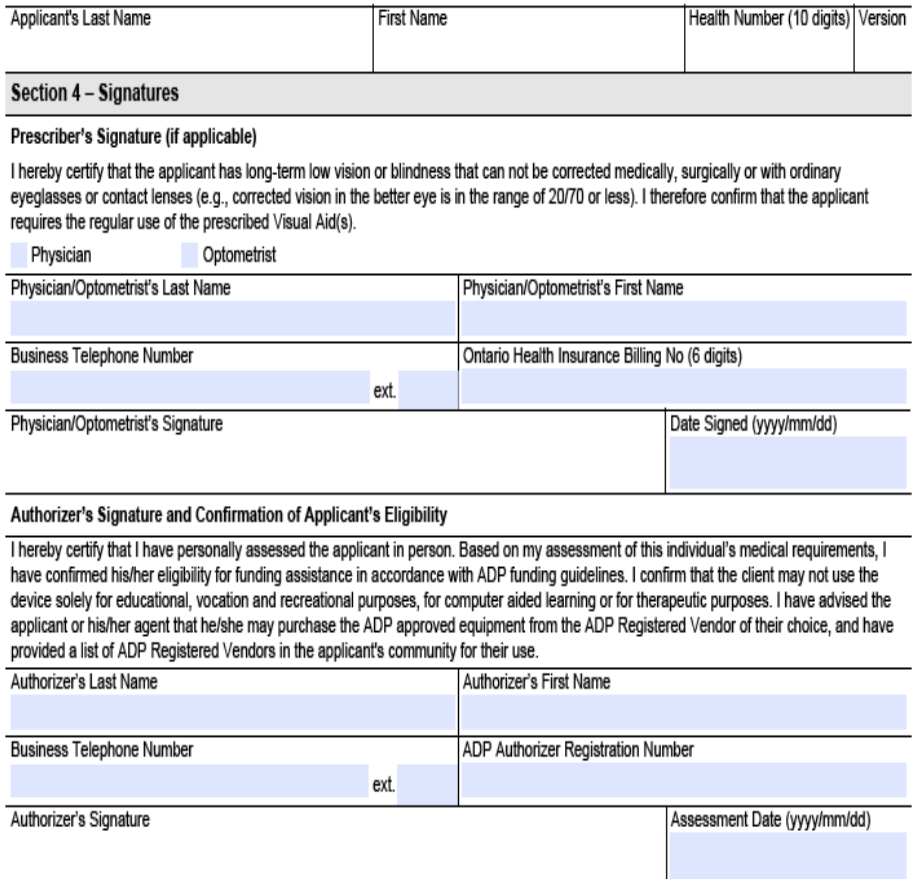
The prescriber's **6-digit OHIP billing number** is required.

Health professionals signing the ADP application form must read and understand the consenting statements within their section of the application form.

Signatures must be original and made in ink.

The authorizer must provide their ADP registration number, assessment date and sign the application. Applications expire one year after authorizer signs.

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



Applicant's Last Name	First Name	Health Number (10 digits)	Version

Section 4 – Signatures

Prescriber's Signature (if applicable)

I hereby certify that the applicant has long-term low vision or blindness that can not be corrected medically, surgically or with ordinary eyeglasses or contact lenses (e.g., corrected vision in the better eye is in the range of 20/70 or less). I therefore confirm that the applicant requires the regular use of the prescribed Visual Aid(s).

☐ Physician ☐ Optometrist

Physician/Optometrist's Last Name	Physician/Optometrist's First Name

Business Telephone Number	Ontario Health Insurance Billing No (6 digits)
ext.	

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

Authorizer's Signature and Confirmation of Applicant's Eligibility

I hereby certify that I have personally assessed the applicant in person. Based on my assessment of this individual's medical requirements, I have confirmed his/her eligibility for funding assistance in accordance with ADP funding guidelines. I confirm that the client may not use the device solely for educational, vocation and recreational purposes, for computer aided learning or for therapeutic purposes. I have advised the applicant or his/her agent that 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.

Authorizer's Last Name	Authorizer's First Name

Business Telephone Number	ADP Authorizer Registration Number
ext.	

Authorizer's Signature	Assessment Date (yyyy/mm/dd)

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Section 4 – Signatures: Vendor Information

Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number

Vendor Representative's Last Name	Vendor Representative's First Name

Position Title	Business Telephone Number
	ext.

Vendor Location

Vendor Representative's Signature	Date (yyyy/mm/dd)

ADP Vendor Registration Number

All vendors registered with ADP are issued a unique ADP vendor registration number. Applications with invalid vendor registration numbers or submitted by vendors not registered with the program will not be approved.

Vendor Representative Information

The vendor representative must sign and date the form.

Signatures must be original and made in ink.

Vendors must review the information provided for accuracy. Incorrect or incomplete information may delay the application processing

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Submitting the Application Form

- Only original applications signed in ink will be processed.
- Photocopies of applications, scanned/e-mailed applications and faxed applications will not be accepted.
- Vendors MUST retain a copy of the original application for their records.
- Verify that all sections have been completed accurately prior to submitting. Applications with missing or incorrect information will not be approved.
- The use of correction fluid/tape to correct information will not be accepted.
- Submitted application forms that are incomplete, or are incorrectly completed, will not be approved and/or will be subject to processing delays.

Vendor Responsibilities

Vendors have a number of responsibilities as part of the ADP. A full list is available in the Visual Aids Policy and Administration Manual.

- Orders and provides prompt delivery of the Authorized Device specified on the Application Form.
- Provides counseling and instructions necessary for the proper and effective use, operation, care and maintenance for all Devices sold.
- Provides the Applicant with a fully itemized invoice for the Authorized Device purchase together with a copy of the manufacturer's warranty and user manual. The original invoice must be kept with the applicant's file together with a copy of the application form. The ADP may request a copy of the invoice at any time.
- Honours manufacturer's warranties for the benefit of Clients and provides after-sales service such as repair and maintenance services.
- Provides repair quotes, as necessary, to the Applicant and/or to the ADP.
- Retains all supporting documentation on file and provide to the ADP as requested.

Common Mistakes and Omissions

Mistakes and Omissions result in delays to the application, here are a few common mistakes which may delay the application processing and put payment on hold:

- Invalid health card number or personal information does not match information in the OHIP files (e.g. date of birth or legal name)
- Applicant/agent details and signature missing
- Application has expired
- Inconsistent physician contact details
- Replacement reason missing
- No device selected
- Device code on invoice does not match ADP device type on application (refer to Product Manuals)
- Invoiced quantity exceeds the maximum allowable quantity
- Invoice received date is more than one year after the delivery date
- Delivery date is more than 1 year after the claim assessment date
- Invoice number has been previously used by the vendor and is not unique

Application Delays/Denials

Applications may be delayed/denied for a number of reasons. Although not exhaustive, here are a list of common reasons:

Delays

- Prescriber billing number is incorrect, signature or date missing
- Authorizer or vendor registration number is incorrect, signature or date is missing.
- Replacement must be selected if the device is being replaced.
- Multiple reasons for funding provided e.g. first-access and replacement.

Denials

Applicant does not meet eligibility requirements for the visual aid, e.g. applicant is not eligible for health services (OHIP) on the assessment date.

Applicant has exceeded the number of devices permitted for the funding period.

Additional Resources

- Policies and Procedures Manual for the ADP
- Visual Aids Policy and Administration Manual
- Applicant Information Sheet
- Visual Aids Application Form
- Visual Aids Product Manual