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

Section 3 – Applicant's Consent and 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 (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	☐ Applicant * ☐ Agent *	Date (yyyy/mm/dd)

If the above signature is not that of the applicant, specify relationship to applicant and fill out contact information

☐ 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.

This page must be completed and submitted

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

Section 4 – Signatures

Authorizer's Signature

I hereby certify that I have personally assessed the applicant named on this form in person, I have confirmed his/her eligibility for funding assistance in accordance with all ADP funding guidelines, I have authorized the equipment described on this form based on a comprehensive clinical assessment, and have taken all safety and environmental concerns into consideration. I have advised the applicant or his/her agent that (i) 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 or (ii) have informed the applicant or his/her agent about the policies and procedures of the ADP Central Equipment Pool for High Technology Wheelchairs (CEP).

Authorizer's Last Name	Authorizer's First Name
Business Telephone Number ext.	ADP Authorizer Registration Number
Authorizer's Signature	Assessment Date (yyyy/mm/dd)

Vendor/Vendor Representative Information

1. Vendor Business Name | ADP Vendor Registration Number

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 Representative (Last Name, First Name)	Position Title
Vendor Location	Business Telephone Number ext.
Vendor Representative's Signature	Date Signed (yyyy/mm/dd)

2. Vendor Business Name | ADP Vendor Registration Number

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 Representative (Last Name, First Name)	Position Title
Vendor Location	Business Telephone Number ext.
Vendor Representative's Signature	Date Signed (yyyy/mm/dd)

Equipment Specifications (Ambulation Aids Only)

Vendor Invoice Number	Vendor's ADP Registration Number	Base Device
ADP Device Code (Base Device)	Description of Item (Make & Model)	ADP Portion
Serial Number		Client Portion

Proof of Delivery

I confirm that I have received the mobility device described above and that I have received a fully itemized invoice from the vendor for the device described above. I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

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

This page must be completed and submitted