Ontario

Ministry of Health and Long-Term Care

Assistive Devices Program

Hearing Device Application

The collection of the information on this form and the collection of the results of hearing tests are authorized under the *Ministry of Health Act*, R.S.O. 1990, c.M.26, section 6 (1) to determine eligibility for financial assistance under the Assistive Devices Program (ADP). For further details concerning this collection, please contact the Manager, Registration and Claims, Assistive Devices Program, 5700 Yonge Street, 7th Floor, Toronto ON M2M 4K5, telephone (416) 327–8804, toll free 1 800 268-6021, TDD: 1 800 387–5559, facsimile (416) 327–8192.

It is an offence to knowingly provide false information on this application.
Please print. Facsimile or photocopies of this form are not acceptable.

DH

I consent to the collection of the information on this form by ADP vendors and authorizers on behalf of the Ministry of Health and Long-Term Care where such information is required by the Ministry to process this application.

Section 1 – To be completed and signed only by Applicant or Agent

Last name of applicant *(print)* | First name | Initials | Date of birth *(d/m/y)* | 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 am applying as the result 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 hearing equipment through the Department of Veterans Affairs "Group A" insurance benefits. ☐ yes ☐ no
- I am eligible to receive funding for hearing equipment through the Workplace Safety & Insurance Board (WSIB).* ☐ yes ☐ no
- I have read and understand the Assistive Devices Program fact sheet for the device I am purchasing. ☐ yes ☐ no

I understand that as an applicant for ADP funding I may purchase my hearing equipment from any vendor registered with ADP and that I may obtain the locations of these vendors from my ADP registered authorizer, or directly from the Ministry of Health and Long-Term Care.

I authorize the release of the information on this form by the Ministry of Health and Long-Term Care to its agents, the ADP registered vendor indicated on this form, my insurance company and any other third party payer that the Ministry may need to consult with to verify eligibility for ADP funding.

*I consent to the collection and disclosure of medical and non-medical information by the Assistive Devices Program (ADP) to the Workplace Safety & Insurance Board (WSIB), and by the WSIB to the ADP, to determine my eligibility to receive assistance from the ADP.

The equipment listed in Section 3 will be used to assist me in my total daily activities and is not for exclusive use in sports, school or work.

Signature of applicant or agent | Correspondence to be sent to ☐ Applicant ☐ Agent | Date *(d/m/y)*

If agent, last name *(print)* | First name | Area code Telephone no.

Address of agent *(print)*
Apt. no. | Street

City | Province | Postal code

Section 2 – To be completed by Physician or Audiologist

Check either 1 or 2 only:

1. ☐ I certify that the above named person has a hearing loss sufficient to warrant the use of hearing aids/FM system on a long term basis as part of his/her total daily activities, and is not for exclusive use in sports, school or work.

2. ☐ I certify that the above named person has a hearing loss severe enough to impede normal use of the telephone even with the use of a hearing aid and a voice amplified telephone, and requires the use of a TDD/TTY on a long term basis.

Request for early replacement *(to be completed by Otolaryngologist or Otologist)*

☐ significant change in hearing *(min. 20dB loss across 3 speech frequencies)* in the previously funded ear. Please attach recent and previous audiograms.

☐ significant change in medical condition. *Please specify (print clearly).*

Audiologist College Reg. no. | Prescriber name *(print)*

Signature of Physician

Health Insurance billing no. | Area code Telephone no. | Date *(d/m/y)*

Signature of Audiologist

DH

Section 3 – To be completed by ADP Registered Authorizer and Dispenser

Authorizer to complete				Vendor to complete	
Description of item: Brand/Model	L	R	ADP catalogue no.	*Unit price ($)	Serial no.

* Unit Price – enter the cost of the item based on a quantity of one.

Total invoice $

ADP portion $

I certify that I have seen the above named applicant and that I have authorized the hearing aid equipment based on my assessment of this individual's medical requirements.

Signature of ADP Registered Authorizer

Signature of ADP Registered Dispenser

ADP authorizer registration no.

ADP dispenser registration no.

Area code Telephone no.

Date *(d/m/y)*

ADP prior authorization no.

Date *(d/m/y)*

Section 4 – PROOF OF DELIVERY – To be completed and signed only by Applicant or Agent

- I received the hearing equipment specified in Section 3 and I have been advised in writing that I have a minimum 30-day trial period to test the suitability of the equipment. ☐ yes ☐ no
- I received a fully itemized invoice from the vendor for the hearing equipment specified in Section 3. ☐ yes ☐ no

I certify that the information on this form is true, correct and complete to the best of my knowledge. I understand the rules of eligibility for ADP and I am eligible for the equipment specified in Section 3. I do not have similar equipment in working order.

I understand that the vendor may bill me for the equipment if I do not meet the ADP's criteria for funding.

Signature of applicant or agent

Date *(d/m/y)*

Section 5 – To be completed by ADP Registered Vendor

I hereby certify that the information on this form is true, correct and complete to the best of my knowledge and that the equipment/supplies as listed have been provided to the above person, per itemized invoice no. _____ , and delivered on _____ *(d/m/y)*. The client will be provided with the minimum 30-day trial period per ADP policy.

Vendor's name *(print)*

Vendor's registration no.

Address

Postal code

Vendor's signature

Area code Telephone no.

Date *(d/m/y)*

Version française disponible.