ASSISTIVE DEVICES FUNDING PROGRAM APPLICATION FORM

Please print in pen.

Note: Assistive Devices Funding Assistance is only available to Individual Members of the Ontario Federation for Cerebral Palsy.

Indicate if you are an Individual Member.

Yes: _____ No: _____

Individual Member Number: _____

Please review the guidelines carefully before submitting your application.

FOR OFFICE USE ONLY

Date Received _____

File Number _____

PLEASE NOTE:
INCOMPLETE APPLICATIONS WILL BE RETURNED.

APPLICANT INFORMATION

Name (who equipment is for): _____
First Name Last Name

Date of Birth: _____
Year / Month / Day

Address: _____

City: _____ Postal Code: _____

Telephone (home): _____ Business: _____

Email: _____

PRIMARY CONTACT (if applicable)

Name of Primary Contact: _____
(parent or guardian required if the applicant is under 18 years) First Name Last name

Relationship to applicant: _____

Address: _____

City: _____ Postal Code: _____

Telephone (home): _____ Business: _____

Email: _____

Equipment/Item/Material Requested: _____

Has above equipment / item / material been ordered or received? Yes _____ No _____

Is Item Covered by ADP?: Yes _____ No _____ Amount Covered $ _____

An item that has been ordered or received does not guarantee approval of funding from this program.

Documentation Required: **Health Professional current rationale letter for all items.** If requested item is covered by ADP Ministry of Health and Long-Term Care, please have your health professional complete enclosed ADP Approval Confirmation Sheet and submit with application.

1. Name of Vendor _____ Quote $ _____

2. Name of Vendor _____ Quote $ _____

Documentation Required - Attach copies from listed vendors.

Cost of the Equipment/Item/Material: $ _____
(Excluding Labour/Installation) Preferred Vendor's Quote

Other Funding you have accessed: If yes to any, please attach agencies/insurance company's letter and the amount that will or will not be covered.

Ontario Disability Support Program (ODSP)	Yes _____	No _____	N/A _____
Employer Extended Health Care Benefits	Yes _____	No _____	N/A _____
Private Insurance	Yes _____	No _____	N/A _____
Other	Yes _____	No _____	N/A _____

(Ex. Service Clubs, Local Community Groups or Businesses, Ministry of Education)

Complete the calculation box below which applies to your request - purchase or lease

Purchase Equipment/Item/Material - Calculation of Request for Financial Assistance

A) Estimated Cost of Equipment/Item/Material (Excluding Labour / Installation) $ _____ Preferred Vendor Quote

B) ADP Approved Amount $ _____ Approved Amount

C) Employer Extended Health Care Benefits $ _____ Amount (attach letter if applicable)

D) Insurance $ _____ Amount (attach letter if applicable)

E) Other Agencies $ _____ Amount (attach letter if applicable)

F) Total Remaining $ _____ A - B - C - D - E = F

TOTAL REQUESTED FROM OFCP $ _____

Lease Equipment - Calculation of Request for Financial Assistance

A) Total Annual Cost to Lease Equipment /Item *Not Total Cost Of Item* $ _____ *Statment of Account / Invioce*

B) Other Agencies $ _____ Amount (attach letter if applicable)

C) Total Remaining $ _____ A - B = C

TOTAL REQUESTED FROM OFCP $ _____ Amount

Indemnity

I hereby indemnify and save harmless the Ontario Federation for Cerebral Palsy, its officers, directors, employees and agents from and against any and all claims, demands, liabilities, losses, costs, expenses, damages, actions, suits and other proceedings arising out of the supply of the equipment described in this application. I understand that the Ontario Federation for Cerebral Palsy acts as a third party funder and as such has no role in prescribing, recommending equipment, selecting a vendor/contractor or in the relationship between the purchaser and vendor of the equipment and that any payment from the OFCP Assistive Devices Funding Program is not an acknowledgment that the equipment is acceptable for the purposes intended.

Privacy

The OFCP collects, uses and discloses personal information related to this application only for the purposes of assessing, processing and administering this application and may exchange such information with the above-mentioned contact person, vendors, medical professionals and other agencies. I consent and (as applicable) confirm the user's consent to this collection, use, disclosure and exchange of personal information.For additional information regarding the OFCP's personal information protection privacy practices, please refer to our Privacy Policy on the OFCP website.

Certification

I certify that the information provided in this application is true, correct and complete to the best of my knowledge and that the equipment has not been received. Approval of this application in this funding year, does not guarantee approval in concurrent years.

By providing your signature below, as the applicant or applicant guardian, you are giving permission to OFCP staff to process your application accordingly and will indicate that you have read the ADFP guidelines and application.

Signature: _____ Date: _____
Year / Month / Day

Relationship to Applicant (if applicable): _____

Please ensure all information and supporting documentation are provided. If any information is missing, the application will be returned for completion, resulting in a delay in processing the request. A copy of the completed form should be kept for your files.

If you have any questions please contact the Ontario Federation for Cerebral Palsy:

416-244-9686 ext: 221
or toll free 1-877-244-9686 ext: 221
Email: adfp@ofcp.ca
Website: www.ofcp.ca

Return the completed form by email (adfp@ofcp.ca), fax (416-244-6543), or mail to:

Ontario Federation for Cerebral Palsy
Assistive Devices Funding Program
1630 Lawrence Avenue West, Suite 104
Toronto, Ontario
M6L 1C5

ADP APPROVAL CONFIRMATION SHEET

Please have your prescribing Health Professional (Occupational or Physiotherapist) complete this sheet if the item you are requesting funding for has been approved by the **Assistive Devices Program (ADP), Ministry of Health and Long-Term Care.**

NAME OF APPLICANT: _____

EQUIPMENT REQUESTED: _____

PURCHASE COST OF EQUIPMENT: _____

AMOUNT APPROVED: _____

DATE APPROVED: _____

EXPIRY DATE OF APPROVAL: _____

Signature of Health Professional: _____

Date: _____

Please include this sheet with the OFCP Assistive Devices Funding Program Application Form