ASSISTIVE DEVICES FUNDING PROGRAM APPLICATION FORM

FOR OFFICE USE ONLY

Date Received ________________________

File Number _________________________

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: _____

PLEASE NOTE: INCOMPLETE APPLICATIONS WILL BE RETURNED.

IF YOU REQUIRE ADDITIONAL INFORMATION OR REQUIRE ASSISTANCE COMPLETING THIS APPLICATION, PLEASE CONTACT US.

Application Date ____________________

Individual Member Number: _______________

Please review the guidelines carefully before submitting your application.

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: ____

Name of designated contact person to assist with communication regarding processing of application if needed (optional):

Contact Name:____

Relationship to applicant: ____

Contact Phone:________________________________

Contact Email:_________________________________

ASSISTIVE DEVICES FUNDING PROGRAM

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 OFCP ADP Approval Confirmation Sheet or provide Ministry of Health 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

NOTE: If you are requesting funding assistance for more than one piece of equipment/item/material please use additional pages.

Other Funding you have accessed: **OFCP requires a copy of written response for funding approved or denied which you received from the Ontario Ministry of Health – ADP, ODSP and/or Assistance for Children with Severe Disabilities Program for the requested item prior to submitting your application to OFCP. OFCP requires that you attach written response to support your OFCP ADFP funding applications.**

Please indicate which (if any) of the provincial programs you are receiving.

- ☐ Ontario Disability Support Program (ODSP)
- ☐ Ontario Works
- ☐ Assistance for Children with Severe Disability (ACSD)
- ☐ None of these

Please check which funding sources you have already applied to:

	Applied	Not Applicable	Approved		Response
			YES	NO	Received in Writing
Ontario Disability Support Program (ODSP)	☐	☐	☐	☐	☐
Ontario Works	☐	☐	☐	☐	☐
Local City Social Services	☐	☐	☐	☐	☐
Assistance for Children with Severe Disability (ACSD)	☐	☐	☐	☐	☐
Community Agencies	☐	☐	☐	☐	☐
Private Insurance	☐	☐	☐	☐	☐
Other ______________________________	☐	☐	☐	☐	☐

(For possible other funding sources, please see attached Addendum A)

Complete the calculation box below which applies to your request

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) Other Funding Obtained

Agency ____________________ $ ____________________
Amount (attach letter if applicable)

Agency ____________________ $ ____________________
Amount (attach letter if applicable)

Agency ____________________ $ ____________________
Amount (attach letter if applicable)

D) Total Remaining $ ____________________
A - B - C = D

TOTAL REQUESTED FROM OFCP $ ____________________
(Including all items) (25% of total cost up to $2000)

NOTE: If you are requesting funding assistance for more than one piece of equipment/item/material please use additional pages.

When was the last time you received funding from ADFP? ____________________

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 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 or the application is incomplete, the applicant or primary contact person will be notified for completion and submission of missing information. **If we do not hear from the applicant within three weeks the application will no longer be active**.

If you require additional information, or require assistance completing this application, or 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 to adfp@ofcp.ca

ASSISTIVE DEVICES FUNDING PROGRAM

OFCP 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