

Assistive Devices Program

The Assistive Devices Program (ADP) of the March of Dimes assists adults with physical disabilities who are in financial need to purchase assistive devices to increase their mobility and functional independence.

It is the ADP's priority to provide funding for devices that will:

- Assist adults with disabilities that restrict their mobility and prevent them from living safely in their homes
- Enable discharge from a hospital or rehabilitation centre
- Help avoid job loss
- Support opportunities for participation in educational, developmental and community activities

An Applicant Assessment Form needs to be completed and submitted to our office for review. There is great demand for the ADP funding and we are unable to provide service to all who qualify. We need the opportunity to review all applications and supporting documentation to identify those with the greatest need. Everyone that submits an Applicant Assessment Form will receive a response by the beginning of the next month.

General Program Criteria

In order to be eligible to receive funding from the Assistive Devices Program (ADP), applicants must meet the following program criteria:

- 1. Be 19 years of age or over;**
- 2. Be an Ontario Resident**
- 3. Possess a valid Ontario Health Card**
- 4. Applicants requesting the following devices are not eligible for funding consideration through this program:**
 - Installation costs
 - Foot orthotics
 - Hearing & vision aids
 - Urinary, ostomy & colostomy supplies
 - Artificial limbs, or cosmetic prostheses
 - Specialized recreational / leisure devices
 - Hospital beds and mattresses or other alternatives for sleeping
 - Devices for prevention and treatment purposes (e.g. TENS machines, exercise equipment)
 - Computers
 - Home Renovations
 - Vehicle Modifications
 - Portable Ramps
- 5. Financial Eligibility**
 Those served by the program must be in financial need.
 - Maximum income allowed is based on net income of the applicant and/or spouse.
 - Persons included in family size are the applicant and/or spouse and/or dependent children under the age of 18.
 - The following chart highlights the maximum allowable income based on family size:

Family Size	Maximum Income Allowed
1 person	\$ 23,658
2 people	\$ 28,039
3 people	\$ 34,372
4 people	\$ 41,180
5 people	\$ 46,361
6 people	\$ 51,959

If you do not meet the above program criteria, you are not eligible for assistance from the Assistive Devices Program. You may choose not to proceed with completing this Applicant Assessment Form.

- The responses to questions on this form should be answered by, or on behalf of, the person with a disability, who is referred to as the "Applicant".
- Applicants requiring more than one device are requested to complete this form based on the device with the most urgent need. Other devices will be considered once program eligibility is determined.

Are you applying for: Mobility Device Home & Bath Safety Equipment Electronic Aid for Daily Living

Funding required for: Purchase of New Equipment Repair of Existing Equipment

Applicant Information

This section must be completed in full. We recommend that you keep a copy of all documents submitted to the program.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.			Date of Birth (mm/dd/yy):		
First Name:		Initial(s):	Last Name:		
Street No.:	Street Name:			Apt No.:	
City:		Province:		Postal Code:	
Telephone:		Fax:	E-mail:		

Designated Contact Person

(only complete this section require us to communicate with someone other than yourself)

This section allows the applicant to appoint an individual to act on their behalf for the purposes of the Application Process. Reasons to appoint a Designated Contact Person: a language barrier exists or your health status and/or unavailability prevents you from communicating with ADP.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Name:		
First Name:		Initial(s):	Last Name:		
Street No.:	Street Name:			Apt No.:	
City:		Province:		Postal Code:	
Telephone:		Fax:	E-mail:		

Relationship to Applicant:

Healthcare Professional Information

Same as designated contact OT PT Chiroprapist Orthopedic Surgeon Podiatrist

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Name:		
Company:					
Telephone:		Fax:		E-mail:	

General Program Criteria

1. Are you a permanent resident of Ontario?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have a disability, or an ongoing or recurring impairment, anticipated to last more than one year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Does your disability/impairment impede mobility and result in substantial restrictions to daily living activities, e.g., self-care, functioning in the community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you and your spouse/common-law partner in receipt of ODSP or Ontario Works as your only source of income?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. Please select the statement(s) below that best describe the purpose of the device being requested:

- a. This device will allow me to exercise by increasing muscle tone, strength train, or increase my metabolism as recommended by my doctor
- b. This device will be used for the prevention and/or effective management of pain.
- c. This device will promote walking independence, and is an over-the-counter orthopedic shoe and/or molded orthotic not part of a knee ankle foot orthosis (KAFO) or ankle foot orthosis (AFO)
- d. This device will promote my safety and independence in my current living situation and/or in the outside community.

Disability Information

Which of the following best describes your permanent disability:

<input type="checkbox"/> Age related problems	<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> Paraplegia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Polio
<input type="checkbox"/> Chronic Heart Failure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Post Polio
<input type="checkbox"/> Cerebral Vascular Accident	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Post Polio Syndrome
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke

Other (please specify):

Ethnic Background

(Please note: this information will be used for statistical purposes only. It is not a required field.)

- | | | |
|---|--|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Eastern European (Russian, Polish, Czech) | <input type="checkbox"/> Native Canadian / American |
| <input type="checkbox"/> Other Asian countries | <input type="checkbox"/> Greek | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Central American | <input type="checkbox"/> Indian, Pakistani | <input type="checkbox"/> Scandinavian (Swedish, Norwegian, Danish, Finnish) |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Irish | <input type="checkbox"/> South American |
| <input type="checkbox"/> German | <input type="checkbox"/> Italian | <input type="checkbox"/> Spanish, Portugese |
| <input type="checkbox"/> English, Scottish, Welsh | <input type="checkbox"/> Japanese | <input type="checkbox"/> West Indian |
| <input type="checkbox"/> Other European | <input type="checkbox"/> Mexican | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> French | <input type="checkbox"/> Middle Eastern | |

Financial Eligibility

This section must be completed in order to determine financial eligibility for the program. Please note that if the combined net income exceeds the maximum income allowed, the applicant will not be eligible for financial assistance through this program.

The income of the following people are considered: •Applicant •Spouse/ Common Law/Life Partner

Net Income (Tax Form Line 236)	Applicant: \$	Spouse/ Common Law/Life Partner: \$	Total Combined Income: \$
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married/Common Law/Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Number of Dependent Children Living at Home (under age 18):			
Source of Income:	<input type="checkbox"/> Employment <input type="checkbox"/> CPP <input type="checkbox"/> OAS <input type="checkbox"/> ODSP/OW <input type="checkbox"/> Other (specify):		

Client Eligibility Chart

Those served by the program must be in financial need.

- Maximum income allowed is based on net income of the applicant and/or spouse.
- Persons included in family size are the applicant and/or spouse and/or dependent children under the age of 18.
- The following chart highlights the maximum allowable income based on family size:

Family Size	1 person	2 people	3 people	4 people	5 people	6 people
Maximum Income Allowed	\$23,658	\$28,039	\$34,372	\$41,180	\$46,361	\$51,959

Please read the following sections carefully and select the answer that best describes your situation.

1) Purpose – Mobility Aid *(complete this section only if you are requesting a mobility aid)*

<input type="checkbox"/>	a. It will allow me to be independent in the community to access non-vital services or social situations.
<input type="checkbox"/>	b. It will allow me to be independent in the community to access vital services (grocery shopping, banking, postal services or medical services).
<input type="checkbox"/>	c. It will allow me to access current areas of my home that I presently cannot.
<input type="checkbox"/>	d. It will allow me to maintain myself in an independent living situation, or move into one.
<input type="checkbox"/>	e. It will allow me access dining hall and social activities in the facility in which I live.
<input type="checkbox"/>	f. It will allow me to remain out of bed for longer periods of time.
<input type="checkbox"/>	g. It will replace the current seating system in my existing mobility device.

2) Purpose – Home & Bath Safety Equipment *(complete this section only if you are requesting a home & bath safety equipment)*

<input type="checkbox"/>	a. It will ease the work load of my family and caregivers.
<input type="checkbox"/>	b. It will correct an unsafe situation.
<input type="checkbox"/>	c. It will allow me to complete some self-care activities independently but I will still require outreach attendant care services.
<input type="checkbox"/>	d. It will allow me to complete all of my self-care activities independently without outreach attendant care services.

3) Purpose – Electronic Aid to Daily Living *(complete this section only if you are requesting an electronic aid to daily living)*

<input type="checkbox"/>	a. It will allow me to communicate one-on-one, both within my home and in the community.
<input type="checkbox"/>	b. It will allow me to communicate my health care needs.
<input type="checkbox"/>	c. It will allow me to request attention from my caregiver or my attendant worker.
<input type="checkbox"/>	d. It will allow me to work or attend educational programs.
<input type="checkbox"/>	e. It will allow me to operate essential devices in my home, for example, light switches, door opener.

Please read the following questions carefully and select the answer that best describes your situation. Check only one response for each section. All sections must be answered.

4) Productivity

<input type="checkbox"/>	a. This device will allow me to participate in recreational or leisure activities. It will allow me the opportunity to gain access to the community to engage in social interactions, attend group activities, or attend a program/service that I otherwise could not participate in.
<input type="checkbox"/>	b. The device will allow me the opportunity to become a productive member of society through educational classes.
<input type="checkbox"/>	c. This device will allow me to maintain my current employment.
<input type="checkbox"/>	d. This device will allow me to access the community for volunteer work.
<input type="checkbox"/>	e. This device will allow me to leave my residence and access the community to prevent social isolation.
<input type="checkbox"/>	f. This device will allow me the freedom to access the community without having to rely on others for transportation.
<input type="checkbox"/>	g. This device will have no impact on my ability to complete productive work.

5) Improvement of Current Situation

<input type="checkbox"/>	a. My access to my home and/or the community will be enhanced.
<input type="checkbox"/>	b. I would be able to return home from the hospital/institution where I am currently residing. Expected discharge date is less than 2 months from the current date.
<input type="checkbox"/>	c. I would be able to return home from the hospital/institution where I am currently residing. Expected discharge date is more than 2 months from the current date.
<input type="checkbox"/>	d. I would be able to access essential and frequent medical appointments that are required to prolong my life, for example, Dialysis Appointments.
<input type="checkbox"/>	e. I would not have to move to a hospital/institution/long term care facility.
<input type="checkbox"/>	f. I would be able to complete essential activities of daily living.
<input type="checkbox"/>	g. I would be able to continue with responsibilities for myself and/or my children.

6) Personal and Family Supports

Please answer this section from the perspective of the person with a disability. Consider all of the individuals who live in the same home and select the statement that best represents the current living situation.

<input type="checkbox"/>	a. I have no other supports available to me; I am responsible for my own daily care.
<input type="checkbox"/>	b. I have no other supports available to me; I am responsible for my own daily care and that of my dependents.
<input type="checkbox"/>	c. I have external support/care (attendant care) at schedule times or when needed for my daily care.
<input type="checkbox"/>	d. I have full-time (24 hour) attendant care services available.
<input type="checkbox"/>	e. I have support from others living in the same home for my daily care.

7) Frequency and Duration of Use

<input type="checkbox"/>	a. This device will be used daily, but for less than 12 months of the year.
<input type="checkbox"/>	b. This device will be used daily for 12 months of the year.
<input type="checkbox"/>	c. This device will be used once per week or less for 12 months of the year.
<input type="checkbox"/>	d. This device will be used 2-3 times per week for 12 months of the year.

Please select only one of the following statements:

<input type="checkbox"/>	a. The anticipated use of this device is less than one year.
<input type="checkbox"/>	b. The anticipated use of this device is for 1-3 years.
<input type="checkbox"/>	c. The anticipated use of this device is for 3-5 years.
<input type="checkbox"/>	d. The anticipated use of this device is in excess of 5 years.

March of Dimes Privacy Statement

March of Dimes is committed to handling any personal information that we may collect concerning you and your family member(s) in a professional, respectful, and lawful manner. March of Dimes collects, uses, and discloses personal information in accordance with this privacy statement and our privacy policy. The personal information about you and your family member(s) is used for the purposes of:

- i) administering the Assistive Devices Program, including processing your application(s) for funding assistance
- ii) contacting you about the status of your application(s)
- iii) obtaining feedback about March of Dimes services you receive
- iv) providing information about March of Dimes to you and others
- v) complying with the laws and regulations that require the collection, use and disclosure of personal information in connection with the Assistive Devices Program.

The personal information collected about you and your family member(s) includes information supplied by you in your application for funding assistance and any additional or updated information which we may collect from you in the future.

Client Authorization

I hereby certify that the information I have provided above is true and correct to the best of my knowledge.

Name of Applicant or Designated Contact Person (Please Print):

Signature	Date (mm/dd/yy):
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Please submit your completed Applicant Assessment Form to the Assistive Devices Program at the address below. Please ensure all questions are answered (except where noted), and that the form has been signed and dated.

The Mailing Address is: March of Dimes
 Assistive Devices Program
 717 Richmond Street, Unit 5
 London, ON N6A 1S2

Phone: 1-866-765-7237
 Fax: 519-434-3712
 Email: adp@marchofdimes.ca