Ministry of Health

Assistive Devices Program Medical Professionals Training

Ventilator Equipment and Supplies
Completing the Application for Funding

July 2023

Ontario

Introduction

This document is a step-by-step guide to completing the ADP Ventilator Equipment and Supplies Application for Funding accurately.

Equipment is provided by the Ventilator Equipment Pool located in Kingston, ON. This equipment is on loan to the client. Supplies can be purchased from any vendor of the client’s choosing.

For specific information related to eligibility criteria, see the Policy and Administration Manual - Grants.

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Assessment and Application Process

Assessment and Application Process

The life enhancing equipment is provided to Ontarians by the Ventilator Equipment Pool (VEP). Can only be prescribed by a physician specialist with an expertise in assessment, care and management of individuals who need this equipment.

1. Once assessed and deemed eligible for this equipment the physician completes the Application Form and Addendum which can be found on the ADP website.
2. Application and Addendum is sent to the VEP at vepapplication@kingstonhsc.ca. Physician to keep the original document.
3. VEP reviews the application and determine if the Applicant is eligible for the prescribed device(s) and if grant funding is appropriate
4. If approved the VEP will communicate this to the ADP to ensure appropriate records and prepare to ship the equipment to the delivery location on the Addendum.
5. If ineligible for equipment VEP will inform the prescribing physician
6. Equipment shipped to delivery location. Clients can contact VEP for some supplies like probes for Oxygen Saturation Monitor.
7. If eligible for the supply grant clients to receive funding every 4 months – can use to purchase soft goods at location of their choice.

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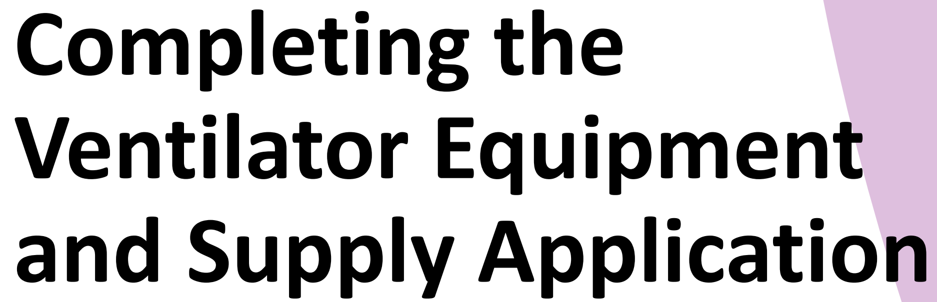
Completing the
Ventilator Equipment
and Supply Application

Section 1

Applicant's Biographical Information

All information in Section 1 – Applicant's Biographical Information must be provided.

Important: Confirm that applicant information recorded on the application (name, date of birth) matches the information contained on the applicant's health card.

Section 1 – Applicant's Biographical Information

Last Name *

First Name * | Middle Initial

Health Number (10 digits) | Version | Date of Birth (yyyy/mm/dd)

Name of Long-Term Care Home (LTCH) (if applicable)

Address

Unit Number | Street Number

Street Name *

Lot/Concession/Rural Route *

City/Town * | Province* ON | Postal Code*

Home Telephone Number | Business Telephone Number ext.

Section 1

Confirmation of Benefits

All information in Section 1 – Confirmation of Benefits must be provided.

Important: You must answer “Yes” or “No” to each Confirmation of Benefits statement.

Applicants eligible for funding through Workplace Safety and Insurance Board (WSIB) or Veterans Affairs Canada (VAC) are not eligible for funding through the program.

Confirmation of Benefits

I am receiving social assistance benefits ☐ Yes ☐ No

If yes, please check one
- ☐ Ontario Works Program (OWP)
- ☐ Ontario Disability Support Program (ODSP)
- ☐ Assistance to Children with Severe Disabilities (ACSD)

I am eligible to receive coverage for Ventilator Equipment or Supplies from:

Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No

Veterans Affairs Canada (VAC) ☐ Yes ☐ No

I am a resident of a Long-Term Care Home (LTCH) ☐ Yes ☐ No

I reside in an acute or a chronic care hospital ☐ Yes ☐ No

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Section 2

Devices and Diagnosis

All information in Section 2 – Devices and Diagnosis must be provided.

- Correct device(s) and if supplies is associated with the prescribed device(s) are selected.
- Grant payments will be provided to client for ventilator supplies.
- Applicant must meet medical eligibility criteria for the prescribed device
    - Ventilator
    - BPAP-ST
    - Oxygen Saturation Monitor
    - Mechanical In-Exsufflation

Section 2 – Devices and Diagnosis (to be completed by Physician)

Devices/Supplies Required (check as applicable)

☐ Ventilator ☐ Bilevel Positive Airway Pressure System with backup rate (BPAP-ST) ☐ Oxygen Saturation Monitor (OSM)

☐ Ventilator Supplies ☐ Mechanical In-Exsufflation

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Section 2

Devices and Diagnosis

All information in Section 2 – Devices and Diagnosis must be provided.

- Physician MUST answer all the questions in Section 2 related to the device(s) being prescribed by checking the appropriate box with either Yes, No or N/A.

Confirmation of Applicant's Medical Eligibility

For Ventilator devices

1. Applicant has a chronic respiratory illness and requires a ventilator for life support — Yes / No / N/A

For BPAP-ST devices

2. Applicant has a chronic respiratory illness and requires a BPAP-ST device with a backup rate — Yes / No / N/A
3. Applicant has a diagnosis of Obstructive Sleep Apnea Syndrome (OSAS), Obesity Hypoventilation, or Central Sleep Apnea (if Yes, provide supporting documentation) — Yes / No / N/A
4. Applicant and/or family is aware that this device is not for life support — Yes / No / N/A

For Oxygen Saturation Monitor devices

5. Applicant is 18 years of age or younger and has a chronic respiratory illness and requires an oxygen saturation monitor — Yes / No / N/A
6. Applicant is unable to notify caregiver and is:
   a. technologically dependent **and**
   b. at risk of a profound hypoxemic event
   — Yes / No / N/A
7. The prescribing physician has privileges at the following hospital(s): (check as applicable)
   - Bloorview Kids Rehab (Toronto)
   - Children's Hospital of Eastern Ontario (Ottawa)
   - Hamilton Health Sciences Centre (Hamilton)
   - The Hospital for Sick Children (Toronto)
   - London Health Sciences Centre (London)
   - Sunnybrook Health Sciences Centre (Toronto)
   - Kingston General Hospital (Kingston)

For Mechanical In-Exsufflation devices

8. Applicant has a diagnosis of neuro-muscular disease, post-polio, spinal cord injury or a condition with weak respiratory muscles or paralysis — Yes / No / N/A
9. Applicant is at risk of or ventilator-assisted — Yes / No / N/A
10. Applicant has documented objective evidence of a weak cough with Peak Cough Flows < 270 L/min with Lung Volume Recruitment and/or Manually Assisted Cough. — Yes / No / N/A

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Section 3

Applicant's Consent and Signature

All information in Section 3 – Applicant's Consent and Signature must be provided.

Note:

- The applicant/agent must read the consent statement before signing.
- Their signature confirms that they have read and understand this section of the application form.
- The signing agent must disclose their relations to the applicant, provide their contact information and have the proper authority to make health decisions on behalf of the applicant.

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.

If the applicant or any other resident of the applicant's household smokes, the applicant on behalf of their heirs and assigns, releases Her Majesty the Queen in the right of the Province of Ontario as represented by the Minister of Health and Long-Term Care, her employees and agents from any responsibility for any damages or losses that may occur as a result of smoking and concurrent use of oxygen.

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 and complete 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: ON	Postal Code
Home Telephone Number	Business Telephone Number ext.

Section 4

Physician Signature

All information in Section 4 – Signatures must be provided including:

- Health Insurance Billing Number required
- Business telephone number
- Signature of Physician
- Signature date

Important: Resident doctors with temporary billing numbers, are not allowed to sign the form.

Section 4 – Signatures

Physician Signature

I hereby certify that the Applicant has a chronic respiratory illness or disability requiring the long-term use of the device(s) specified above. The Applicant has been instructed and has received training on the use of the equipment.

Physician's Last Name		Physician's First Name
Business Telephone Number	ext.	Ontario Health Insurance Billing Number (6 digits)
Physician's Signature		Date Signed (yyyy/mm/dd)

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Completing the Addendum

Section 1

Applicant's Information

All information in Section 1 – Applicant's Information must be provided.

Important: Confirm that applicant information recorded on the application (name, date of birth) matches the information contained on the applicant's health card.

Section 1 – Applicant's Information		
Last Name	First Name	Middle Initial
Health Card Number (10 digits)	Version	

Section 2

Diagnosis

All information in Section 2 – Diagnosis must be provided.

- Physician to indicate primary and secondary diagnosis.
- If Other diagnosis – make sure to specify.

Section 2 – Diagnosis: physician to indicate primary and secondary diagnosis

☐ **Neuromuscular Disorders**

☐ Amyotrophic lateral sclerosis ☐ Muscular Dystrophy (specify) ______

☐ Diaphragm paralysis ☐ Spinal Cord Injury ☐ SMA

☐ **Chest Wall Deformities**

☐ Kyphoscoliosis ☐ Other (specify) ______

☐ **Central Respiratory Drive Depression**

☐ Drugs - (e.g. Narcotics) ☐ Neurological disorders (e.g. Trauma, stroke, multiple sclerosis)

☐ **Obesity Hypoventilation Syndrome**

☐ **Obstructive Sleep Apnea Syndrome (OSAS)**

☐ Complicated OSAS ☐ CPAP intolerant ☐ CPAP-emergent Central apnea

☐ **Chronic Obstructive Pulmonary Disease (COPD)**

☐ **Other** (specify)

Section 3

Equipment Details

All information in Section 3 – Equipment Details must be provided.

Note:

- Ensure that all information related to device(s) is completed.

Section 3 – Equipment Details

Ventilator

Ventilator | Quantity ☐ 1 ☐ 2

Circuit Type | Ventilator Settings

Ventilator Interface ☐ Mask ☐ Mouthpiece ☐ Tracheostomy

Bi-Level ST

Inspiratory Time (Ti) | IP | EP | Rate | Humidifier ☐ Yes ☐ No | Quantity ☐ 1 ☐ 2

Hours of Ventilation/Ventilation Assist ☐ < 12 ☐ 12-24 ☐ 24

Battery ☐ Yes ☐ No | Charger ☐ Yes ☐ No | Cable ☐ Yes ☐ No

Mechanical In-Exsufflation

Settings

Insp. Pressure | Exp. Pressure

Saturation Monitor (max of 2 years)

Start Date (yyyy/ | yy/mm/dd)

Section 3. Mechanical In-Exsufflation. Settings. Insp. Pressure.

Alarm Setting

High Sp02 | Low Sp02

High HR | Low HR

Section 4

Equipment Delivery Instructions

All information in Section 4 – Equipment Delivery Instructions must be provided.

Note

- When delivering equipment to facility ensure that the name, address and contact information is filled out currently.

Section 4 – Equipment Delivery Instructions

Deliver to

Client's Home

Client's Home Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		City/Town	Province	Postal Code
Telephone Number				

Facility

Facility Address

Facility Name

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		City/Town	Province	Postal Code

Facility Contact Person

Last Name	First Name

Floor Number	Room Number	Telephone Number ext.
Email Address		

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Section 4

Physician Signature

All information in Section 4 – Physician Signature must be provided.

Note:

- Physician who signed Application Form should sign the Addendum.

Physician Signature		
Physician Last Name	Physician First Name	
Physician Signature		Date Signed (yyyy/mm/dd)

Submitting the Application Form and Application Process

Submitting the Application Form

- Application and Addendum should be sent directly to the Ventilator Equipment Pool at: vepapplication@kingstonhsc.ca
- Physician's office/hospital MUST retain the original application form and Addendum for their records.
- Verify that all sections have been completed accurately prior to submitting.

Rejected or Denied Applications

An applicant will be deemed ineligible if:

- Applications that are incomplete, inaccurate or are submitted for individuals who are ineligible for the program funding will not be approved. See Policy and Procedure Manual – Grants for eligibility criteria.
- Applications that are submitted without the addendum will not be approved.
- The physician does not sign and date the addendum.

Additional Resources

- Policies and Procedures Manual for the ADP
- Policy and Administration Manual - Grants
- Application for Funding Ventilator Equipment and Supplies
- Addendum for Ventilator Equipment and Supplies Application Form

Contact Information

Ventilator Equipment Pool Contact Information

VEP Website:
https://ontvep.ca/

Mailing Address:

c/o Kingston Health Sciences
640 Cataraqui Wood Drive, unit #6
Kingston, Ontario
K7P 2Y5

Email: vep@kingstonhsc.ca

Telephone: 613-548-6156

Toll Free: 1-800-633-8977

Assistive Devices Program Contact Information

ADP Website:

General Public Website

Health Professionals Website

Mailing Address:

Program Coordinator, Ventilator Equipment and Supplies

Assistive Devices Program (ADP)
7th Floor, 5700 Yonge Street
Toronto, Ontario
M2M 4K5

Email: adp@ontario.ca

Telephone: 416-327-8804

Toll Free: 1-800-268-6021

TTY: 416-327-4282

Toll Free TTY: 1-800-387-5559