



# ASSISTIVE DEVICES FUNDING PROGRAM APPLICATION FORM

Please print in pen. Faxed copies will not be accepted.

**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 \_\_\_\_\_

Individual Member Number \_\_\_\_\_

## APPLICANT INFORMATION

Name (who equipment is for): \_\_\_\_\_  
First Name Last Name

Date of Birth: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Year / Month / Day *Cerebral palsy support documentation required*

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: \_\_\_\_\_

# 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 \$ \_\_\_\_\_

*Documentation Required. If 'Yes', have your prescribing Health Professional (ie: Occupational or Physiotherapist) complete enclosed 'ADP Approval Confirmation Sheet' and submit with application. If 'No', attach your Health Professional's current authorization indicating the need for the requested equipment, item or material.*

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 \_\_\_\_\_

(ie. 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 <small>(Excluding Labour / Installation)</small>	\$		<small>Preferred Vendor Quote</small>
B) ADP Approved Amount	\$		<small>Approved Amount</small>
C) Employer Extended Health Care Benefits	\$		<small>Amount (attach letter if applicable)</small>
D) Insurance	\$		<small>Amount (attach letter if applicable)</small>
E) Other Agencies	\$		<small>Amount (attach letter if applicable)</small>
F) Total Remaining	\$		<small>A - B - C - D - E = F</small>
TOTAL REQUESTED FROM OFCP	\$		

### Lease Equipment - Calculation of Request for Financial Assistance

A) Total Annual Cost to Lease Equipment /Item <small>Not Total Cost Of Item</small>	\$		<small>Statement of Account / Invoice</small>
B) Other Agencies	\$		<small>Amount (attach letter if applicable)</small>
C) Total Remaining	\$		<small>A - B = C</small>
TOTAL REQUESTED FROM OFCP	\$		<small>Amount</small>

## ASSISTIVE DEVICES FUNDING PROGRAM

### 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.

By providing your signature below, as the applicant or applicant guardian, you are giving permission to OFCP staff to process your application accordingly

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: 234  
or toll free 1-877-244-9686 ext: 234  
Email: [adfp@ofcp.ca](mailto:adfp@ofcp.ca)  
Website: [www.ofcp.ca](http://www.ofcp.ca)

Return the completed form by 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*



# INDIVIDUAL MEMBERSHIP APPLICATION FORM

Please print in pen.

Date of Application: \_\_\_\_\_  
Year / Month / Day

Date of Birth: \_\_\_\_\_  
Year / Month / Day

You are (check one):

- Person with cerebral palsy  
(cerebral palsy support documentation required)
- Parent/Family member of a person with cerebral palsy
- Professional / Supporter who has an interest in the welfare of persons with cerebral palsy  
(Professional / Supporter applicants must complete questions 1 – 3 on page 2.)

<b>FOR OFFICE USE ONLY</b>	
Date Received	_____
Date Approved	_____
Membership #	_____
Amount Paid	_____
Renewed - Date	_____

## APPLICANT INFORMATION

Name: \_\_\_\_\_  
First Name
Last Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Homephone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## CONTACT PERSON NAME (if applicant is under 18 years of age)

Name: \_\_\_\_\_  
First Name
Last Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Homephone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## NOTE

- A person employed by the OFCP is ineligible for membership.
- A person employed by an OFCP Member Group is ineligible for membership.
- A person who is currently a member of a Member Group can become an Individual Member but cannot vote as an Individual Member.

## Professional / Supporter - please complete questions 1 – 3.

1. Why do you want to join the OFCP as an individual member?

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2. Do you have a special skill that could help OFCP in meeting its objectives?

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3. Reference, if you are a Professional/Supporter, from an OFCP member in good standing.

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## Your Membership Includes

- Individual members who have cerebral palsy are eligible to apply for funding assistance from OFCP for equipment, vacation and community based day programs.
- Individual members in good standing are entitled to one vote at all OFCP General Meetings provided that they did not vote as a member of a member group. Members will receive mail outs throughout the year, including the OFCP newsletter, InformAction.

## Membership Fees

- Persons with cerebral palsy are required to pay initial \$10.00 membership fee for life-time membership; Individuals who are members of the OFCP Member Groups are automatically considered as individual members of the OFCP but must still complete an Individual Membership application form.
- Parents, family members, professionals and supporters are required to pay annual \$10.00 membership fee;
- Membership fee is non-refundable.

## Disclaimer

The OFCP collects, uses and discloses personal information related to this application only for the purposes of assessing, processing and administering this application for individual membership with the above-mentioned applicant/contact person. I consent and (as applicable) confirm the user's consent to this collection, use, disclosure of personal information. For additional information regarding the OFCP Privacy policy please refer to the OFCP website, [www.ofcp.ca](http://www.ofcp.ca)

Signature of Applicant: \_\_\_\_\_

If you have any questions, please contact the Ontario Federation for Cerebral Palsy at 416-244-9686 or 1-877-244-9686. **Please return completed form by mail to:**

Ontario Federation for Cerebral Palsy  
1630 Lawrence Avenue West, Suite #104  
Toronto, Ontario, M6L 1C5