MARCH OF DIMES CANADA | LA MARCHE DES DIX SOUS DU CANADA

ADP Applicant Assessment

Applicant Information

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.			Date of Birth *(mm/dd/yy)*:
First Name:		Initial(s):	Last Name:
Street No.:	Street Name:		Apt No.:
City:	Province: ONTARIO		Postal Code:
Telephone:	Fax:		E-mail:

Designated Contact Person

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ 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:

Assistive Device Information (check one box only)

☐ Mobility Device ☐ Home & Bath Safety Equipment ☐ Electronic Aid for Daily Living

Reason: ☐ New Device Purchase OR ☐ Existing Device Repair

Total dollars requested from March of Dimes $ _____

For office use only:
C #_____ Job # ADP_____

Shortcut Code: _____

Date received:

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Funding Sources

Check off all agencies you have applied to for funding:

- ☐ Applicant / Family Contribution
- ☐ Ministry of Health ADP
- ☐ Extended Health Benefits
- ☐ Other (specify): _____
- ☐ ODSP
- ☐ March of Dimes Canada
- ☐ Community Service Clubs
- ☐ MS Society
- ☐ Social Services
- ☐ Muscular Dystrophy Association
- ☐ ALS

Record the source name, response and the dollar amount from each source:
(use another piece of paper if more sources are to be identified)

Funding Source	Date of Application (mm/dd/yy)	Contact Name and Phone	Amount Funded

Financial Eligibility (Please refer to the ADP Application Guide)

Net Income (Tax Form Line 236)	Applicant: $
	Spouse/ Common Law/Life Partner: $
	Total Combined Income: $

Marital Status: ☐ Single ☐ Married/Common Law/Life Partner ☐ Divorced ☐ Separated ☐ Widowed

Number of Dependent Children (under the age of 18):

Source of Income:	☐ Employment ☐ CPP ☐ OAS ☐ ODSP/OW ☐ Other *(specify)*:

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Disability Information

Please check all that apply in relation to your need for the device(s) you are requesting.

- ☐ Age related problems
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Arthritis, Osteoarthritis, Osteoporosis
- ☐ Spina Bifida
- ☐ Diabetes
- ☐ Cerebral Palsy
- ☐ Dementia/Alzheimer's
- ☐ Amputee
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Paraplegia
- ☐ Muscular Dystrophy
- ☐ Stroke
- ☐ Quadriplegia
- ☐ Post Polio Syndrome
- ☐ Chronic Heart Failure
- ☐ Spinal Cord Injury
- ☐ Polio
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Other *(please specify)*:

Cause of Disability: ☐ Congenital ☐ Acquired Date disability started:

Ethnic Background

The March of Dimes strives to reach to all populations. We are collecting information on your ethnic background for statistical purposes only to ensure that we are reaching all groups. Completing this section is voluntary and is not required.

- ☐ Canadian / North American
- ☐ French
- ☐ Middle Eastern
- ☐ African
- ☐ Eastern European (Russian, Polish, Czech)
- ☐ Native Canadian / American
- ☐ Other Asian countries
- ☐ Greek
- ☐ Puerto Rican
- ☐ Central American
- ☐ Indian, Pakistani
- ☐ Scandinavian
- ☐ Chinese
- ☐ Irish
- ☐ South American
- ☐ German
- ☐ Italian
- ☐ Spanish, Portuguese
- ☐ English, Scottish, Welsh
- ☐ Japanese
- ☐ West Indian
- ☐ Other European
- ☐ Mexican
- ☐ Other *(specify)*:

Questionnaire

1a) Mobility Device

Complete this section only if you are requesting a mobility device. Then go to Questions 2 – 7.

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

1b) Home & Bath Safety Equipment

Complete this section only if you are requesting Home & Bath Safety Equipment. Then go to Questions 2 – 7.

- ☐ a. It will correct an unsafe situation.
- ☐ b. It will ease the work load of my family and caregivers.
- ☐ c. It will allow me to complete some self-care activities independently but I will still require support from others.
- ☐ d. It will allow me to complete all of my self-care activities independently without support from others.

1c) Electronic Aid for Daily Living

Complete this section only if you are requesting an Electronic Aid for Daily Living. Then go to Questions 2 – 7.

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

2) Productivity

- ☐ a. This device will allow me to participate in community recreational or leisure activities both within and outside of my place of residence.
- ☐ b. This device will allow me to participate in community recreational or leisure activities within my place of residence.
- ☐ c. This device will allow me to access the community for volunteer work.
- ☐ d. The device will allow me to pursue or continue my education.
- ☐ e. This device will allow me to seek or maintain my current employment.
- ☐ f. This device will have no affect on my ability to participate in the community.

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3) Improvement of Current Situation

- ☐ a. I would be able to complete basic activities of daily living within my home, such as bathing, toileting, dressing, eating, communicate with others, or move from room to room
- ☐ b. My access to my community and/or independence would be enhanced, such as shopping, banking, or do light housework. I am already able to complete basic activities of daily living within my home.
- ☐ c. Access to my community would be enhanced, and I will also be able to access essential and frequent medical appointments that are required to prolong my life, for example, dialysis appointments.
- ☐ d. I would be able to return home from the hospital/institution where I am currently residing.
- ☐ e. I would be able to access areas of my hospital/institution/long term care facility.

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4) Dependents

Consider all of the individuals who live in the same home and select the statement that best represents the current living situation. For the purposes of this question, a dependent is a child, senior, or person with a disability who relies on the applicant for daily care in activities such as meal preparation, bathing, and shopping needs.

- ☐ a. I have no dependents.
- ☐ b. I have one dependent.
- ☐ c. I have two dependents.
- ☐ d. I have three or more dependents.

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5) Support

- ☐ a. I have no other supports available to me; I am responsible for my own daily care.
- ☐ b. I only have external support (ie: attendant care) at scheduled times or when needed for my daily care.
- ☐ c. I have external support full-time (24 hour) (ie: long term care facility)
- ☐ d. I only have family support on a part-time basis (ie: family member is at work during the day).
- ☐ e. I only have family support on a full-time basis. (ie: retired spouse).
- ☐ f. I have both external and family supports.

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6) Frequency of Use

- ☐ a. This device will be used daily, but for less than 12 months of the year.
- ☐ b. This device will be used daily for 12 months of the year.
- ☐ c. This device will be used once per week or less for 12 months of the year.
- ☐ d. This device will be used 2-3 times per week for 12 months of the year.

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7) Duration of Use

- ☐ a. The anticipated use of this device is less than one year.
- ☐ b. The anticipated use of this device is for 1-3 years.
- ☐ c. The anticipated use of this device is for 3-5 years.
- ☐ d. The anticipated use of this device is in excess of 5 years.

March of Dimes Canada Privacy Statement

March of Dimes Canada 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 Canada 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 Canada services you receive
iv) providing information about March of Dimes Canada 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.

March of Dimes Canada Release of Information

March of Dimes Canada is pleased to provide you with service. From time to time we are interested in receiving your feedback and would like to send you information to help us better serve you. Our Quality Service policy is…

> "*to ensure that anyone affiliated with March of Dimes Canada recognizes all internal and external contacts as customers and is committed to delivering Quality Service to each and every one of them*".

In order to conduct customer satisfaction surveys or to tell you about other services, we request your permission to contact you.

Thank you for your assistance.

I agree that March of Dimes Canada may contact me for the following reasons: *(check all that apply*)

- ☐ To obtain feedback on services I receive from March of Dimes Canada
- ☐ To advise me of new information or services that may be of interest to me
- ☐ To provide me with a volunteer opportunity
- ☐ To solicit my view on services or policies affecting people with disabilities
- ☐ Do Not Contact

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Client Authorization
I hereby declare that the information I have provided in this application is accurate and without omission, and I authorize March of Dimes Canada to obtain or release personal information to process my request and to verify the information that I have declared in this application.

Name of Applicant (Please Print):

Signature of Applicant	Date

Please submit your complete Applicant Assessment Form and required documents to the Assistive Devices Program through mail, fax, or online.

The contact/mailing information is:	Required Documents
March of Dimes Canada Assistive Devices Program 291 King Street, 3rd Floor London, ON N6B 1R8 Phone: 1-866-765-7237 Fax: 519-432-4923 Website: www.marchofdimes.ca/adp Email: adp@marchofdimes.ca	Use this checklist to ensure your application package includes: ☐ Completed Applicant Assessment form ☐ One (1) Price Quotation ☐ Letter of Assessment/Prescription ☐ Proof of Income ☐ Ministry of Health's Response (for Mobility Device(s) only)