



**ONTARIO FEDERATION FOR CEREBRAL PALSY
ASSISTIVE DEVICES FUNDING PROGRAM**

FOR OFFICE USE ONLY

Date Received _____

File Number _____

OFCP Contact _____

Date Approved _____

Cheque Issued _____
Year / Month / Day

Amount \$ _____

APPLICATION FORM

Please print in pen.

Faxed copies will not be accepted.

Date of Request: _____
Year / Month / Day

I would like to be added to your mailing list. Yes ___ No ___

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: _____

Contact Information:

(Must be complete if applicant under 18 years) _____
First Name Last Name

Relationship to the Applicant: _____

Address: _____

City: _____ Postal Code: _____

Telephone: Home: _____ Business: _____

Email: _____

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>

Have you received funds from OFCP before: Yes _____ No _____ Date: _____
Month / Day / Year

Specify Amount: \$ _____ Item(s) _____



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: _____
Relationship to Applicant: _____ Year / Month / Day

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.on.ca
Website: www.ofcp.on.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**