Ministry of Health

Assistive Devices Program
Vendor Training

Home Oxygen Therapy
Completing the Application for Funding and Submitting Invoices.

July 2023

Ontario

Introduction

This document is a step-by-step guide to completing the ADP application for funding for Home Oxygen Therapy (initial and renewal of funding).

For specific information related to eligibility criteria, see the Home Oxygen Therapy Policy and Administration Manual.

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Completing the Home Oxygen Therapy Application for Initial Funding and Renewal of Services

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.	

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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.

Note: Local Health Integrated Network has transitioned to Home and Community Care Support Services (HCCSS)

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 Home Oxygen benefits from

- Workplace Safety & Insurance Board (WSIB) ☐ Yes ☐ No
- Veterans Affairs Canada (VAC) – Group A ☐ 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

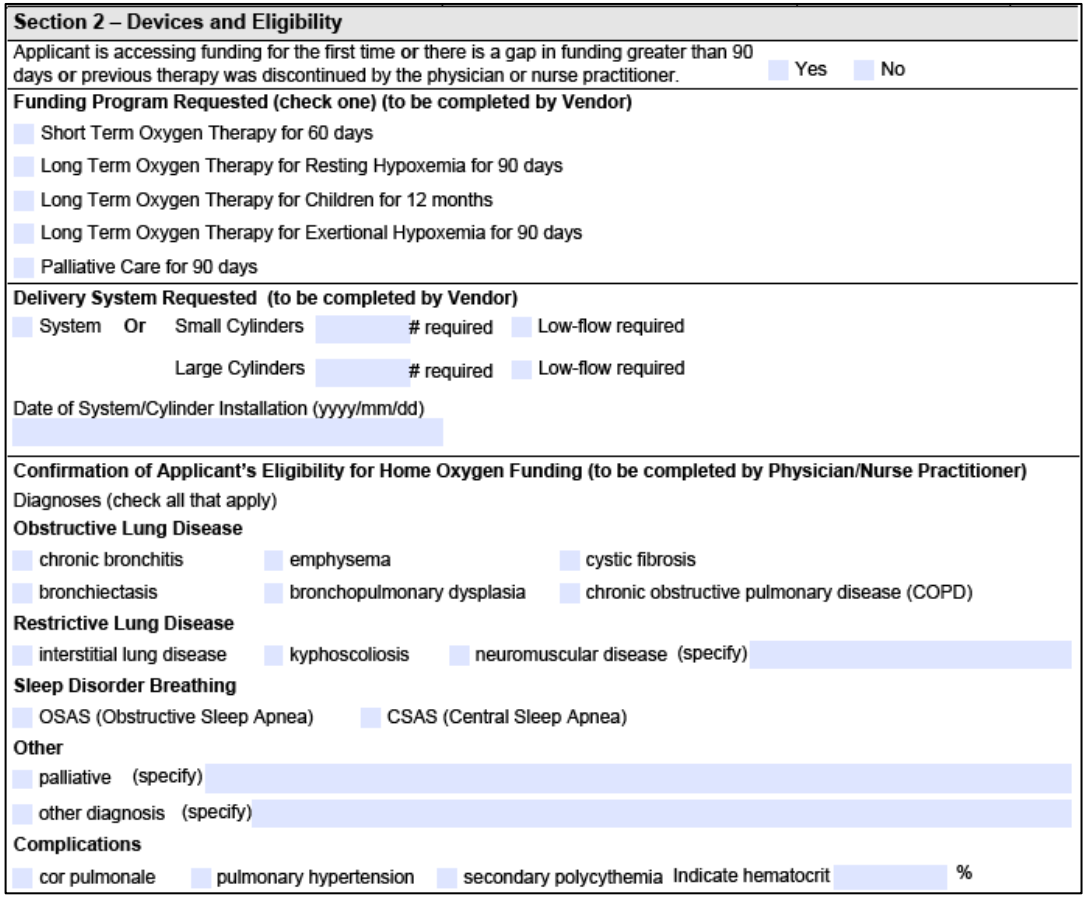
I am receiving professional services through the Local Health Integration Network (LHIN) ☐ Yes ☐ No

Section 2

Devices and Eligibility for Initial Funding

All information in Section 2 – Devices and Eligibility must be provided including:

- Confirmation that applicant is accessing funding for the first time/gap in funding >90 days/previous therapy discontinued;
- Funding program requested;
- Delivery system requested and actual equipment was installed in applicant's home; and
- Applicant's medical diagnosis/condition (*to be completed by physician/NP*)



Section 2 – Devices and Eligibility

Applicant is accessing funding for the first time or there is a gap in funding greater than 90 days or previous therapy was discontinued by the physician or nurse practitioner. ☐ Yes ☐ No

Funding Program Requested (check one) (to be completed by Vendor)

☐ Short Term Oxygen Therapy for 60 days
☐ Long Term Oxygen Therapy for Resting Hypoxemia for 90 days
☐ Long Term Oxygen Therapy for Children for 12 months
☐ Long Term Oxygen Therapy for Exertional Hypoxemia for 90 days
☐ Palliative Care for 90 days

Delivery System Requested (to be completed by Vendor)

☐ System Or Small Cylinders _____ # required ☐ Low-flow required

Large Cylinders _____ # required ☐ Low-flow required

Date of System/Cylinder Installation (yyyy/mm/dd) _____

Confirmation of Applicant's Eligibility for Home Oxygen Funding (to be completed by Physician/Nurse Practitioner)

Diagnoses (check all that apply)

Obstructive Lung Disease

☐ chronic bronchitis ☐ emphysema ☐ cystic fibrosis
☐ bronchiectasis ☐ bronchopulmonary dysplasia ☐ chronic obstructive pulmonary disease (COPD)

Restrictive Lung Disease

☐ interstitial lung disease ☐ kyphoscoliosis ☐ neuromuscular disease (specify) _____

Sleep Disorder Breathing

☐ OSAS (Obstructive Sleep Apnea) ☐ CSAS (Central Sleep Apnea)

Other

☐ palliative (specify) _____
☐ other diagnosis (specify) _____

Complications

☐ cor pulmonale ☐ pulmonary hypertension ☐ secondary polycythemia Indicate hematocrit _____ %

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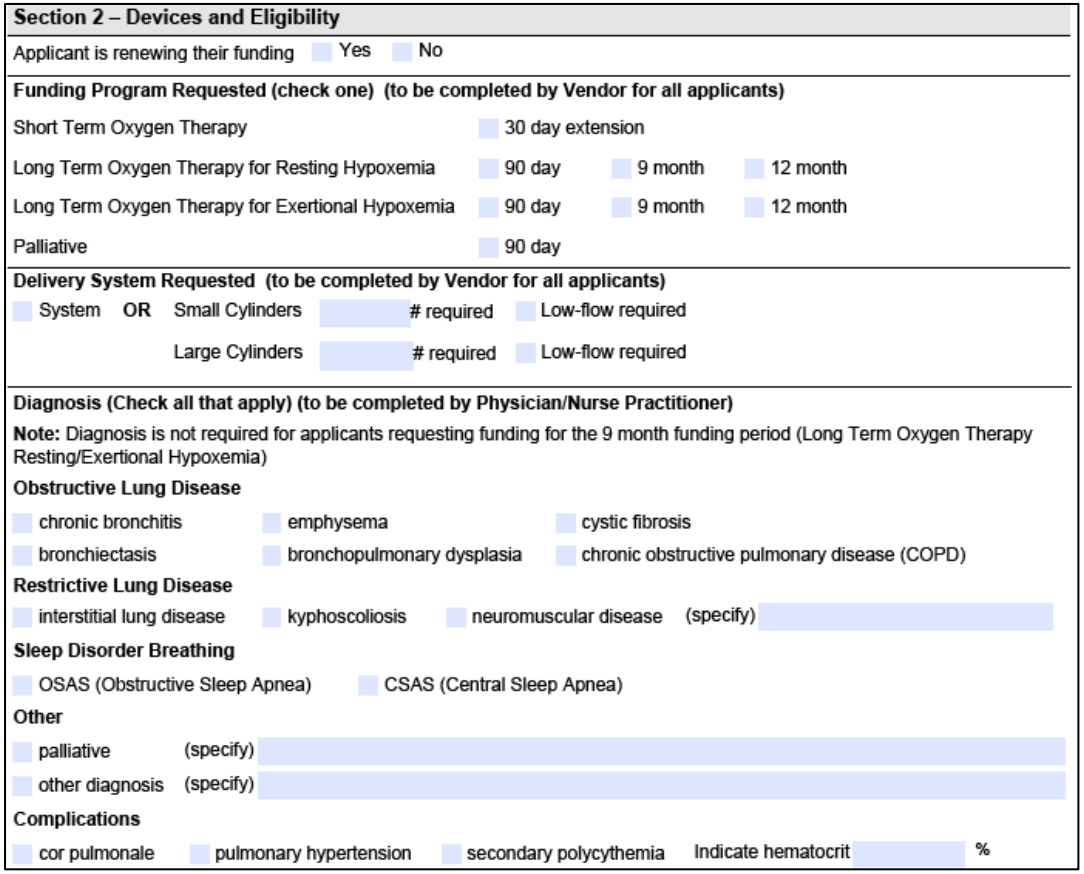
Section 2

Devices and Eligibility for Funding Renewal

All information in Section 2 – Devices and Eligibility must be provided including:

- Confirmation that applicant is renewing their funding
- Funding program requested;
- Delivery system requested and
- Applicant's medical diagnosis/condition (*to be completed by physician/NP*)



Section 2 – Devices and Eligibility

Applicant is renewing their funding ☐ Yes ☐ No

Funding Program Requested (check one) (to be completed by Vendor for all applicants)

Short Term Oxygen Therapy	☐ 30 day extension		
Long Term Oxygen Therapy for Resting Hypoxemia	☐ 90 day	☐ 9 month	☐ 12 month
Long Term Oxygen Therapy for Exertional Hypoxemia	☐ 90 day	☐ 9 month	☐ 12 month
Palliative	☐ 90 day		

Delivery System Requested (to be completed by Vendor for all applicants)

☐ System **OR** Small Cylinders _____ # required ☐ Low-flow required

Large Cylinders _____ # required ☐ Low-flow required

Diagnosis (Check all that apply) (to be completed by Physician/Nurse Practitioner)

Note: Diagnosis is not required for applicants requesting funding for the 9 month funding period (Long Term Oxygen Therapy Resting/Exertional Hypoxemia)

Obstructive Lung Disease

☐ chronic bronchitis ☐ emphysema ☐ cystic fibrosis

☐ bronchiectasis ☐ bronchopulmonary dysplasia ☐ chronic obstructive pulmonary disease (COPD)

Restrictive Lung Disease

☐ interstitial lung disease ☐ kyphoscoliosis ☐ neuromuscular disease (specify) _____

Sleep Disorder Breathing

☐ OSAS (Obstructive Sleep Apnea) ☐ CSAS (Central Sleep Apnea)

Other

☐ palliative (specify) _____

☐ other diagnosis (specify) _____

Complications

☐ cor pulmonale ☐ pulmonary hypertension ☐ secondary polycythemia Indicate hematocrit _____ %

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Section 2

Test Results: ABG/Oximetry Tests

All applicable information in Section 2 – Test Results must be provided including:

- ABG test results for initial 90-day funding period (long-term oxygen therapy) and 60-day funding period (short term oxygen therapy);
- If ABG is not provided, physician or nurse practitioner to confirm ABG could not be taken due to medical risk;
- Oximetry test results to confirm applicant's eligibility (when required) must be provided;
- Confirmation if physician or nurse practitioner performed Oximetry test – and if they did not the Regulated Health Professional who did must sign in the Signatures section.

Test Results

A. Must be completed for all funding programs indicated except Palliative Care (to be completed by Physician/Nurse Practitioner or Regulated Health Professional)

Print-outs of oximetry test results, signed and dated, must accompany this form. ☐ Attached – oximetry test results

ABGs

PaO_2 (mmHg)	Date (yyyy/mm/dd)	☐ ABGs could not be taken due to medical risk

Oximetry (SpO_2)

Rest	Exertion	Sleep
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)	Date (yyyy/mm/dd)

Did physician/nurse practitioner personally perform the oximetry test? ☐ Yes ☐ No

Note: If No, signature section for Health Professional must be filled.

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Section 2

Short Term Oxygen Therapy

All applicable information in Section 2 – Short Term Oxygen Therapy must be provided:

Important: The physician, nurse practitioner or the Registered Respiratory Therapists employed by the acute care hospital must answer “Yes” or “No” to BOTH statements.

B. Short Term Oxygen Therapy (must be completed if Short Term Oxygen Therapy is indicated)
(to be completed by Physician/Nurse Practitioner or Registered Respiratory Therapist)

Note: If this section is completed by a Registered Respiratory Therapist, only the Registered Respiratory Therapist employed by the acute care hospital and who assessed the above applicant’s need for home oxygen therapy can answer the two questions below.

Applicant was an inpatient in an acute care hospital and required home oxygen therapy to be discharged. ☐ Yes ☐ No

Applicant was in the emergency department and required home oxygen therapy to be discharged. ☐ Yes ☐ No

Section 2

Independent Exercise Assessment (IEA) for Initial Funding

All applicable information in Section 2 – Independent Exercise Assessment must be provided including:

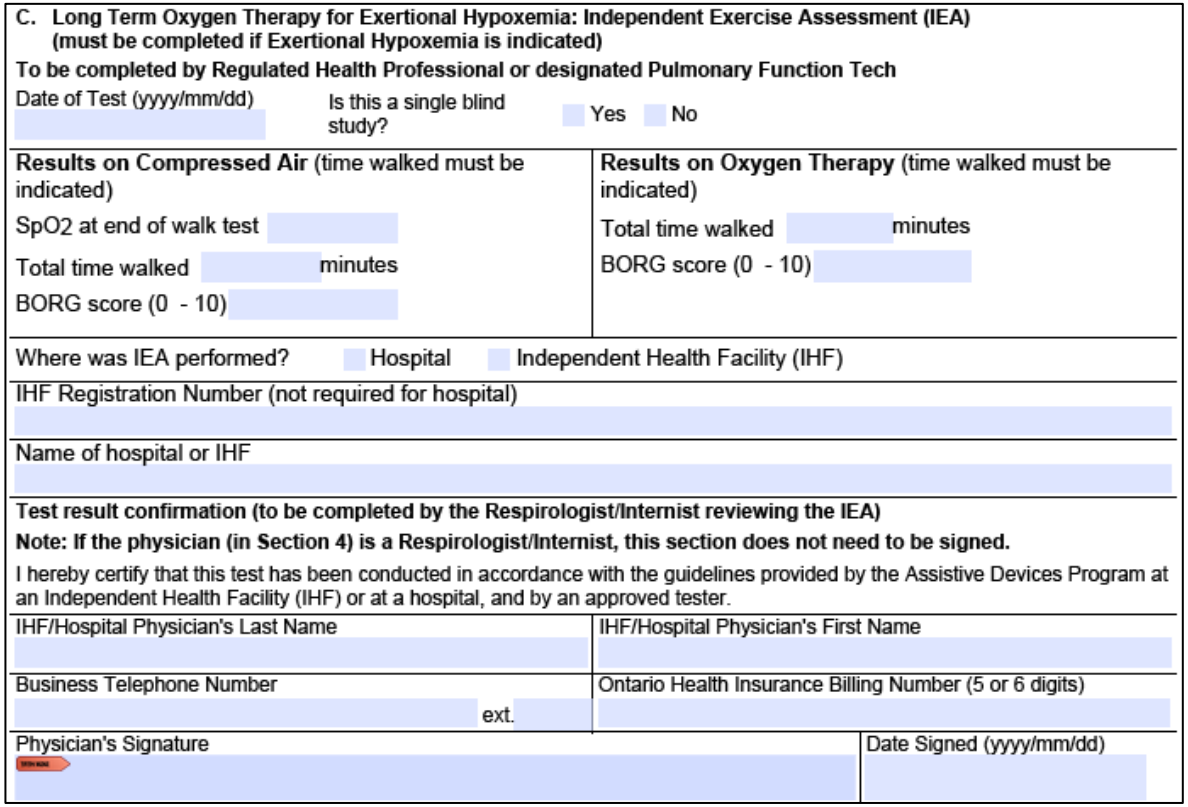
- Date of testing;
- Single blind study (yes or no)
- Type of facility (Hospital or IHF)
- IHF Registration Number (IHF only)
- Name of facility where IEA was performed and
- Respirologist/Internist's information

Results on Compressed Air:

- Sp02 at end of walk test;
- Total time walked; and
- BORG scale

Results on Oxygen Therapy

- Time walked on; and
- BORG scale



C. Long Term Oxygen Therapy for Exertional Hypoxemia: Independent Exercise Assessment (IEA)
(must be completed if Exertional Hypoxemia is indicated)

To be completed by Regulated Health Professional or designated Pulmonary Function Tech

Date of Test (yyyy/mm/dd) | Is this a single blind study? ☐ Yes ☐ No

Results on Compressed Air (time walked must be indicated)	**Results on Oxygen Therapy** (time walked must be indicated)
SpO2 at end of walk test	Total time walked ____ minutes
Total time walked ____ minutes	BORG score (0 - 10)
BORG score (0 - 10)	

Where was IEA performed? ☐ Hospital ☐ Independent Health Facility (IHF)

IHF Registration Number (not required for hospital)

Name of hospital or IHF

Test result confirmation (to be completed by the Respirologist/Internist reviewing the IEA)

Note: If the physician (in Section 4) is a Respirologist/Internist, this section does not need to be signed.

I hereby certify that this test has been conducted in accordance with the guidelines provided by the Assistive Devices Program at an Independent Health Facility (IHF) or at a hospital, and by an approved tester.

IHF/Hospital Physician's Last Name	IHF/Hospital Physician's First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (5 or 6 digits)
Physician's Signature	Date Signed (yyyy/mm/dd)

Ontario

Section 2

Independent/Vendor Exercise Assessment for Renewal

All applicable information in Section 2 – Independent Exercise Assessment must be provided including:

- Date of testing;
- Single blind study (yes or no)

Results on Compressed Air:

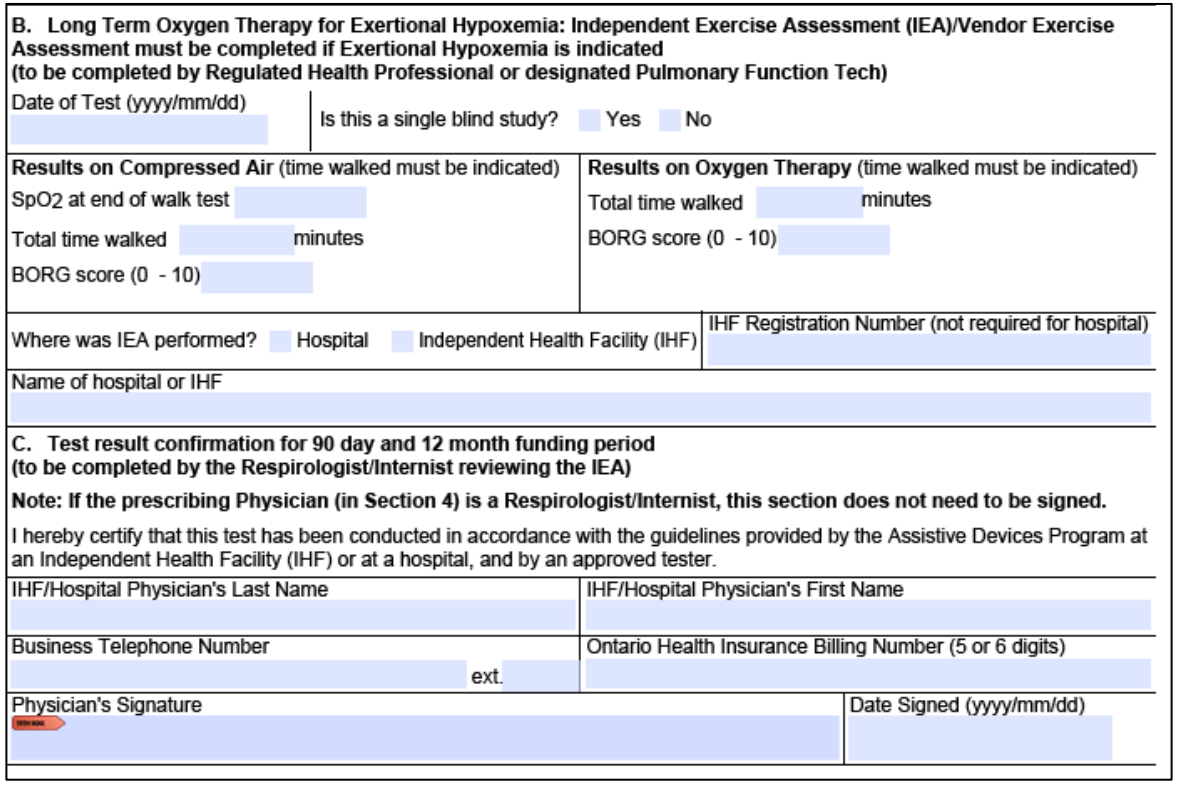
- Sp02 at end of walk test;
- Total time walked and
- BORG scale

Results on Oxygen Therapy

- Time walked on and
- BORG scale

Test Performed at Hospital of IHF:

- Type of facility (Hospital or IHF)
- IHF Registration Number (IHF only)
- Name and facility where IEA was performed
- Respirologist/Internist's information



B. Long Term Oxygen Therapy for Exertional Hypoxemia: Independent Exercise Assessment (IEA)/Vendor Exercise Assessment must be completed if Exertional Hypoxemia is indicated
(to be completed by Regulated Health Professional or designated Pulmonary Function Tech)

Date of Test (yyyy/mm/dd) | Is this a single blind study? Yes No

Results on Compressed Air (time walked must be indicated)
SpO2 at end of walk test
Total time walked minutes
BORG score (0 - 10)

Results on Oxygen Therapy (time walked must be indicated)
Total time walked minutes
BORG score (0 - 10)

Where was IEA performed? Hospital Independent Health Facility (IHF) | IHF Registration Number (not required for hospital)

Name of hospital or IHF

C. Test result confirmation for 90 day and 12 month funding period
(to be completed by the Respirologist/Internist reviewing the IEA)

Note: If the prescribing Physician (in Section 4) is a Respirologist/Internist, this section does not need to be signed.

I hereby certify that this test has been conducted in accordance with the guidelines provided by the Assistive Devices Program at an Independent Health Facility (IHF) or at a hospital, and by an approved tester.

IHF/Hospital Physician's Last Name | IHF/Hospital Physician's First Name

Business Telephone Number ext. | Ontario Health Insurance Billing Number (5 or 6 digits)

Physician's Signature | Date Signed (yyyy/mm/dd)

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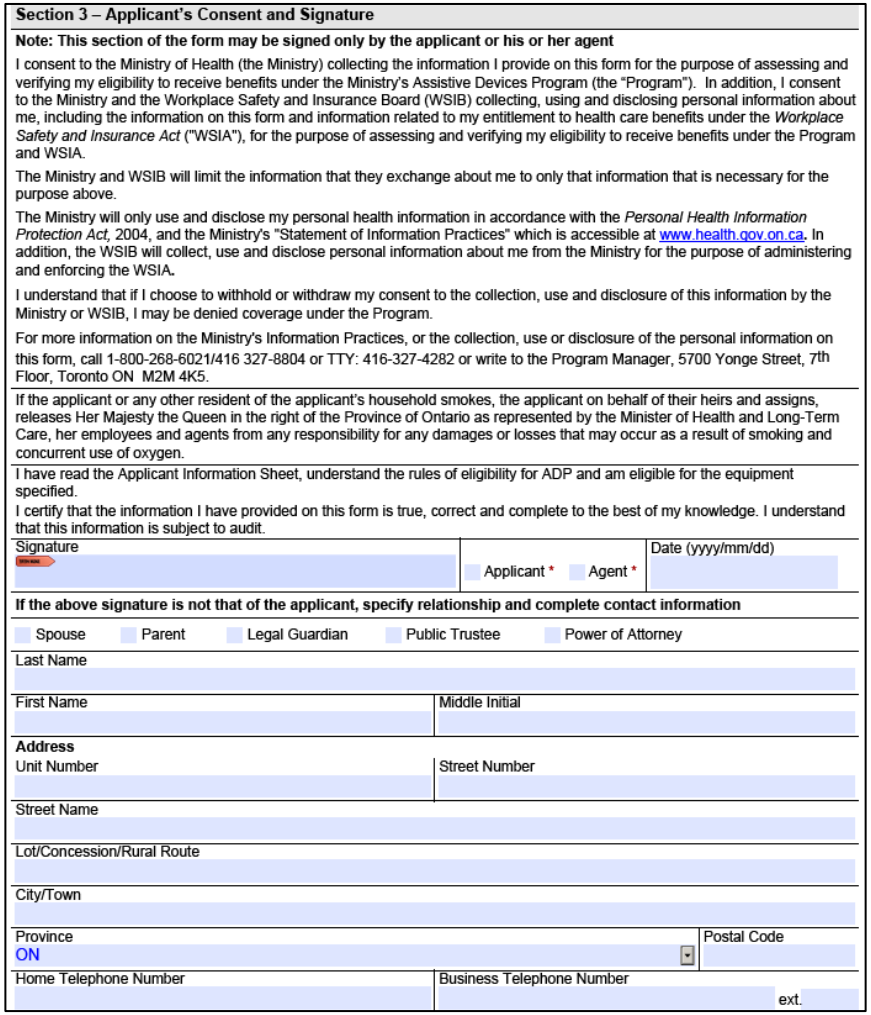
Section 3

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.

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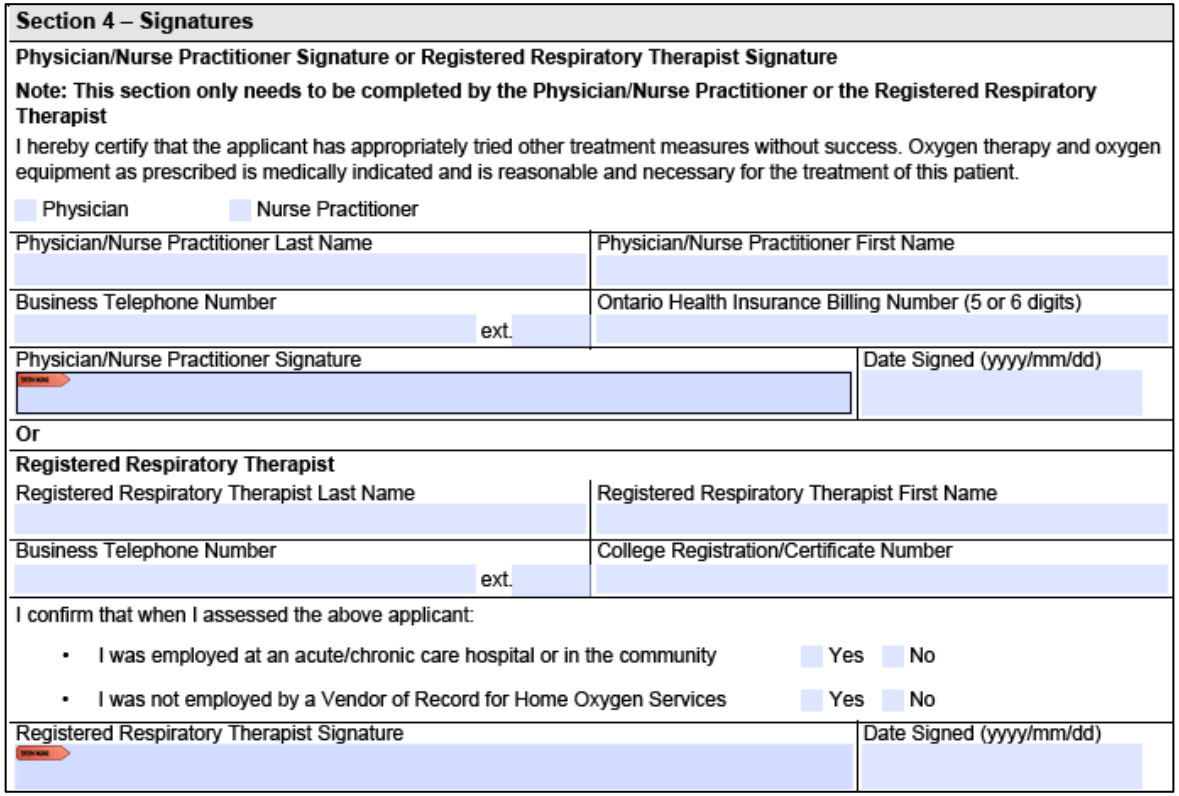
Section 4

Signatures for Initial Funding

All information in Section 3 – Signatures must be provided including:

- Health Insurance Billing Number (where applicable)
- Business telephone number
- Signature of Physician, Nurse Practitioner or Registered Respiratory Therapy
- Signature date

Important: If signed by RRT, the RRT must confirm employment status at time of assessment (answer "Yes" or "No" to both questions).



Section 4 – Signatures

Physician/Nurse Practitioner Signature or Registered Respiratory Therapist Signature

Note: This section only needs to be completed by the Physician/Nurse Practitioner or the Registered Respiratory Therapist

I hereby certify that the applicant has appropriately tried other treatment measures without success. Oxygen therapy and oxygen equipment as prescribed is medically indicated and is reasonable and necessary for the treatment of this patient.

☐ Physician ☐ Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (5 or 6 digits)
Physician/Nurse Practitioner Signature	Date Signed (yyyy/mm/dd)

Or

Registered Respiratory Therapist

Registered Respiratory Therapist Last Name	Registered Respiratory Therapist First Name
Business Telephone Number ext.	College Registration/Certificate Number

I confirm that when I assessed the above applicant:

- I was employed at an acute/chronic care hospital or in the community ☐ Yes ☐ No
- I was not employed by a Vendor of Record for Home Oxygen Services ☐ Yes ☐ No

Registered Respiratory Therapist Signature	Date Signed (yyyy/mm/dd)

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Section 4

Signatures for Renewal

All information in Section 3 – Signatures must be provided including:

- Health Insurance Billing Number
- Business telephone number
- Signature of Physician, Nurse Practitioner
- Signature date

Note: Not required for applicants requesting funding for 9-month funding period, unless a complication is indicated under diagnosis or ABG results are provided.

Section 4 – Signatures

A. Physician/Nurse Practitioner Signature

Note: Signature not required for applicants requesting funding for the 9 month funding period, unless a complication is indicated under diagnosis or ABG results provided.

I hereby certify that the applicant has appropriately tried other treatment measures without success. Oxygen therapy and oxygen equipment as prescribed is medically indicated and is reasonable and necessary for the treatment of this patient.

Physician Nurse Practitioner

Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number ext.	Ontario Health Insurance Billing Number (5 or 6 digits)
Physician/Nurse Practitioner Signature	Date Signed (yyyy/mm/dd)

Ontario

Section 4

Regulated Health Professional Signature

All information in Section 4 – Regulated Health Professional Signature must be provided if:

- Oximetry results are provided in Section 2 (Test Results); and
- Physician or Nurse Practitioner confirmed they did not perform the oximetry study (answered "No" in Section 2 – Test Results).

Regulated Health Professional Signature (section must be filled if Physician/Nurse Practitioner did not complete the oximetry test)

I confirm that I performed a pulse oximetry test on the applicant on the dates noted above. This test was conducted to the best of my ability and the results submitted are listed in Section 2 above.

Last Name	First Name

Profession

Business Telephone Number	College Registration/Certificate Number
ext.	

Signature	Date Signed (yyyy/mm/dd)

The Ministry of Health reserves the right to confirm that the Health Professional indicated above is a member in good standing with the appropriate professional college.

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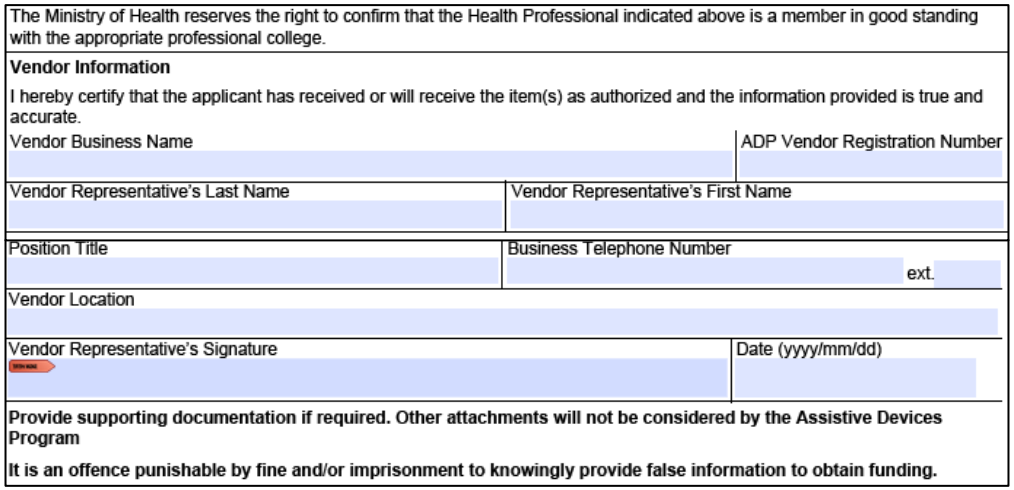
Section 4

Vendor Information

All information in Section 4 – Vendor Information must be provided including:

- Vendor Business Name
- Vendor Registration Number
- Vendor Signature and Date
- Vendor Location and Phone number and
- Vendor Representative – position title, first and last name.



The Ministry of Health reserves the right to confirm that the Health Professional indicated above is a member in good standing with the appropriate professional college.

Vendor Information

I hereby certify that the applicant has received or will receive the item(s) as authorized and the information provided is true and accurate.

Vendor Business Name	ADP Vendor Registration Number

Vendor Representative's Last Name	Vendor Representative's First Name

Position Title	Business Telephone Number
	ext.

Vendor Location

Vendor Representative's Signature	Date (yyyy/mm/dd)

Provide supporting documentation if required. Other attachments will not be considered by the Assistive Devices Program

It is an offence punishable by fine and/or imprisonment to knowingly provide false information to obtain funding.

Ontario

Submitting the Application Form and Application Process

Submitting the Application Form – Initial Funding and Renewal

As of 2020, all submissions for Home Oxygen funding are submitted by eSubmission portal.

Application Approved

Applications that are complete, accurate and submitted for individuals who meet medical eligibility criteria as found in the ADP's Policy and Administration Manuals will be approved for funding.

Errors and Omissions in Application Completion Results in Delays

Applications that are NOT complete, accurate or submitted for individuals who do not meet the medical eligibility criteria will not be approved for funding.

The application will be rejected/denied, and a notification will be sent to the vendor via the Application Status Report or to the vendor/physician by post office with copy of application.

Application Status Report

The Vendor should review the Application Status Report regularly. The Application Status Report will list all applications with activity during the reporting period.

The report is sent out every two weeks.

Status Types

1. **Approved** – Vendor is notified via the Application Status Report.
2. **Not Approved** – Applicant does not meet medical eligibility criteria or there are claim related errors. The report identifies the reason that the claim is not approved. If the claim is denied because the applicant does not meet medical eligibility criteria, only the prescriber can appeal the decision. For claim related errors, the vendor must arrange for the correction.
3. **In Progress** – The application has been received, has been entered in the database and is pending adjudication.

Invoices

Completing the Invoice

There are essential data fields required for all invoices:

- Vendor Registration Number
- Claim number
- Client Health card number (last 4 digits only)
- Vendor Invoice number (a unique number)
- Invoice date
- Delivery date
- Service start date
- Service end date
- ADP device code
- Serial number (leave blank)
- Device Placement (L)eft, (R)ight, (N/A)
- Quantity
- Unit Price
- ADP portion
- Client portion
- Benefit Code*

*One of the following codes must be used:

BENEFIT CODE

- ODS – Ontario Disability Support Program
- OWP – Ontario Works
- ACS – Assistance to Children with Severe Disabilities
- LTC – Client who resides in long-term care home
- CCA – Client who receives professional services through CCAC (LHIN)
- SEN – client who is 65 years or older
- REG – client who is not under a program listed above.

Invoice Processing

Status Types

- Invoices that conform to the ADP payment policies will be processed.
- A valid and payable invoice received by the ADP within 12 months of service end date will be paid.

Inadmissible Files

- Invoices with an invalid file format will not be accepted and a report will be returned immediately to the vendor outlining the problem.
- Invoices submitted in the valid format but containing incorrect or inaccurate data will result in the invoice being placed “on hold” until the vendor corrects the invoice. The invoice status report will provide details of the error and the “on hold” invoice will be retained in the database for a max of 90 days.
- An invoice with a delivery date or service date more than 12 months prior to the receipt of the invoice by the ADP is considered stale-dated and will not be paid to the vendor.
- An invoice requiring a correction must be resubmitted as a revised invoice file.

Remittance Advice

A Remittance Advice is produced when a payment is being made to a vendor. It provides vendors with the details of the payment, such as the invoices paid, and credit notes applied. This report is provided every two weeks, when a payment to the vendor has been generated.

Remittance Advice Details

- Invoice number
- Invoice date
- Claim number
- Client name
- Payment date
- Payment amount

Invoice Status Report

The Invoice Status Report accompanies the Remittance Advice and lists all new or changed invoices and the status of these invoices, every two weeks. Invoices that are “on hold” will include a description of the error.

If the vendor experiences a two-week period where there have been no new invoices submitted, nor any changes to existing invoices, the Invoice Status Report will not be issued.

Inadmissible Files

- Invoices on hold due to errors may only be corrected through a revised electronic invoice file.
- Invoices not corrected within 90 days will be deleted
- An invoice with a delivery date or service date more than 12 months prior to the receipt of the invoice is considered stale-dated and will not be paid to the vendor.

Status Types

- **On Hold** – refers to invoices that cannot be processed and errors are identified
- **Invoice Deleted** – is an invoice “on hold” due to errors that have been deleted by the systems as it has not been corrected within the 90 days window provided.

Invoice Error Messages

Adjudication Error Message	Next Steps/How to Resolve/Check
ADP Vendor is not authorized for the device type Short Term/Regular/Exertional/Palliative Oxygen System as of the Service Start Date	Verify validity of the Vendor registration number and registration date and re-invoice.
Client Health Card Number on the invoice does not match the Client Health Card Number on the claim	Correct the Health Card Number and re-invoice using a unique Invoice Number
Client is 65 years old as of the Service Start Date and eligible for 100 % funding.	Re-invoice for 100% funding using a unique Invoice Number. Subsequent invoices must also be for 100% funding.
Client is deceased before the end of the Service period.	Re-invoice with the correct end date using a unique Invoice Number (deceased date).
Client is ineligible for health services (OHIP) as of the Service Start Date provided on the invoice.	Health Card Number was invalid or inactive as of the service start date. Client must approach OHIP and verify. Also client may be deceased resulting in an inactive Health Card number.

Invoice Error Messages

Adjudication Error Message	Next Steps/How to Resolve/Check
Client is receiving Professional Services through LHIN (Home and Community Care Services) as of the Service Start Date and is eligible for 100% funding.	Re-invoice for 100% funding using a unique Invoice Number. Most recent status update available indicates that client is receiving professional services through LHIN and is therefore eligible for 100% funding. LHIN services are temporary and subject to change.
Client was a resident of an Acute or a Chronic Care hospital between Service Start Date and Service End Date therefore is not eligible for funding during this period.	Vendor must provide proof that the client was not in hospital during the service period.
Incorrect Service period. Service end Date is after Home Oxygen Therapy Discontinued Date.	The service has been discontinued and a new application must be submitted for the client.
ADP Device Code on the invoice does not belong to the approved device type.	Verify if the claim was approved as Short Term, Regular, Exertional or Palliative and re-invoice with the code for the correct device type using a unique Invoice Number.

Invoice Error Messages

Adjudication Error Message	Next Steps/How to resolve/Check
Unit Price exceeds the ADP Approved Price as of the Service Start Date.	Approved device type (Short Term, Regular, Exertional and Palliative) or code may be inappropriate for Northern or Southern rate. Correct and re-invoice using a unique Invoice Number.
Invoice Received Date is more than one year after the Service End Date.	Verify accuracy of dates – if one year or more has passed from since service end date, invoice is stale dated.
Social Assistance Benefits cannot be verified for 100% funding.	Unable to verify Social Assistance status. Vendor or client must provide proof from the clients case worker (MCCSS).
Vendor invoice number has been previously used and must be unique.	The same invoice number cannot be use although the invoice is ON HOLD/deleted. Use a unique invoice number.

Additional Resources

- Policies and Procedures Manual for the ADP
- Policy and Administration Manual - Home Oxygen Therapy
- Application for Funding Home Oxygen Program
- Renewal of Funding Home Oxygen Therapy

Contact Information

Program Contact Information

ADP Website:
https://www.ontario.ca/page/assistive-devices-program

Mailing Address:

Program Coordinator, Home Oxygen Therapy

Assistive Devices Program
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

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