

Ministry of Health

Assistive Devices Program Vendor Training

Home Oxygen Therapy
Completing the Application for Funding and Submitting Invoices
September 2024

Introduction

This document is a step-by-step guide to completing the ADP application for funding for Home Oxygen Therapy.

Note: As of April 1st, 2024, there is only one application form for Home Oxygen Therapy which can be found on the ADP website to be used for initial and renewal funding applications.

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



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) *		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 *	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.

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 Home and Community Care Support Services (HCCSS) Yes No

Section 2

Devices and Eligibility

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

- Initial application
 - Confirmation that applicant is accessing funding for the first time/gap in funding >90 days/previous therapy discontinued – check Yes;
 - Renewal application – check No.
- Funding program requested;
- Delivery system requested (initial and renewal)
- Date of System/Cylinder Installation
 - Initial application – required
 - Renewal application - not required.
- 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Funding Program Requested (check one) (to be completed by Vendor) *	
<input type="checkbox"/> Short Term Oxygen Therapy	
<input type="checkbox"/> Long Term Oxygen Therapy for Resting Hypoxemia	
<input type="checkbox"/> Long Term Oxygen Therapy for Children	
<input type="checkbox"/> Long Term Oxygen Therapy for Exertional Hypoxemia	
<input type="checkbox"/> Palliative Care	
Delivery System Requested (to be completed by Vendor) *	
<input type="checkbox"/> System Or Small Cylinders <input type="text"/> # required <input type="checkbox"/> Low-flow required	
<input type="checkbox"/> Large Cylinders <input type="text"/> # required <input type="checkbox"/> Low-flow required	
Date of System/Cylinder Installation (yyyy/mm/dd) <input type="text"/>	
Confirmation of Applicant's Eligibility for Home Oxygen Funding (to be completed by Physician/Nurse Practitioner) *	
Diagnoses (check all that apply)	
Obstructive Lung Disease	
<input type="checkbox"/> chronic bronchitis	<input type="checkbox"/> emphysema <input type="checkbox"/> cystic fibrosis
<input type="checkbox"/> bronchiectasis	<input type="checkbox"/> bronchopulmonary dysplasia <input type="checkbox"/> chronic obstructive pulmonary disease (COPD)
Restrictive Lung Disease	
<input type="checkbox"/> interstitial lung disease	<input type="checkbox"/> kyphoscoliosis <input type="checkbox"/> neuromuscular disease (specify) <input type="text"/>
Sleep Disorder Breathing	
<input type="checkbox"/> OSAS (Obstructive Sleep Apnea)	<input type="checkbox"/> CSAS (Central Sleep Apnea)
Other	
<input type="checkbox"/> palliative (specify) <input type="text"/>	
<input type="checkbox"/> other diagnosis (specify) <input type="text"/>	
Complications	
<input type="checkbox"/> cor pulmonale	<input type="checkbox"/> pulmonary hypertension <input type="checkbox"/> secondary polycythemia Indicate hematocrit <input type="text"/> %

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. <input type="checkbox"/> Attached – oximetry test results		
ABGs		
PaO2 (mmHg)	Date (yyyy/mm/dd)	<input type="checkbox"/> ABGs could not be taken due to medical risk
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Oximetry (SpO2)		
Rest	Exertion	Sleep
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date (yyyy/mm/dd)	Date (yyyy/mm/dd)	Date (yyyy/mm/dd)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Did physician/nurse practitioner personally perform the oximetry test? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Note: If No, signature section for Health Professional must be filled.		

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 must answer “Yes” or “No” to all THREE 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 3 questions below.

Applicant is an inpatient at a long-term care home and requires home oxygen therapy to prevent an emergency room visit. Yes No

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 Exertional Hypoxemia

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,
- Respiriologist/Internist's information.

Results on Compressed Air:

- SpO2 at end of walk test;
- Total time walked; and,
- BORG scale.

Results on Oxygen Therapy

- Time walked on; and,
- BORG scale.

Note: If the Physician (in Section 4) is a Respirologist/Internist, the section does not need to be signed. If they are not, complete the information requested.

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Hospital <input type="checkbox"/> 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 (4 to 6 digits) []
Physician's Signature []	Date Signed (yyyy/mm/dd) []

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 <i>Workplace Safety and Insurance Act</i> ("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 <i>Personal Health Information Protection Act</i> , 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	<input type="checkbox"/> Applicant * <input type="checkbox"/> Agent *	Date (yyyy/mm/dd)
If the above signature is not that of the applicant, specify relationship and complete contact information		
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Public Trustee <input type="checkbox"/> Power of Attorney		
Last Name		
First Name		Middle Initial
Address		
Unit Number	Street Number	
Street Name		
Lot/Concession/Rural Route		
City/Town		
Province		Postal Code
ON		
Home Telephone Number	Business Telephone Number	ext.

Section 4

Signatures

All information in Section 4 – 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.	
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner	
Physician/Nurse Practitioner Last Name	Physician/Nurse Practitioner First Name
Business Telephone Number	Ontario Health Insurance Billing Number (4 to 6 digits)
ext.	
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	College Registration/Certificate Number
ext.	
I confirm that when I assessed the above applicant:	
<ul style="list-style-type: none"> • I was employed at an acute/chronic care hospital or in the community 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • I was not employed by a Vendor of Record for Home Oxygen Services 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registered Respiratory Therapist Signature	Date Signed (yyyy/mm/dd)

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	
<input type="text"/>		<input type="text"/>	
Profession			
<input type="text"/>			
Business Telephone Number		College Registration/Certificate Number	
<input type="text"/> ext. <input type="text"/>		<input type="text"/>	
Signature		Date Signed (yyyy/mm/dd)	
<input type="text"/>		<input type="text"/>	
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.			

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.

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 Signed (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.	



Submitting the Application Form and Application Process

Submitting the Application Form

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 incomplete will be sent back to the vendor for review and completion.

The application submitted for individuals who do not meet medical eligibility criteria will be rejected/denied. A notification will be sent to the vendor via the report along with a letter sent to the vendor/physician by post.

Application Status Report

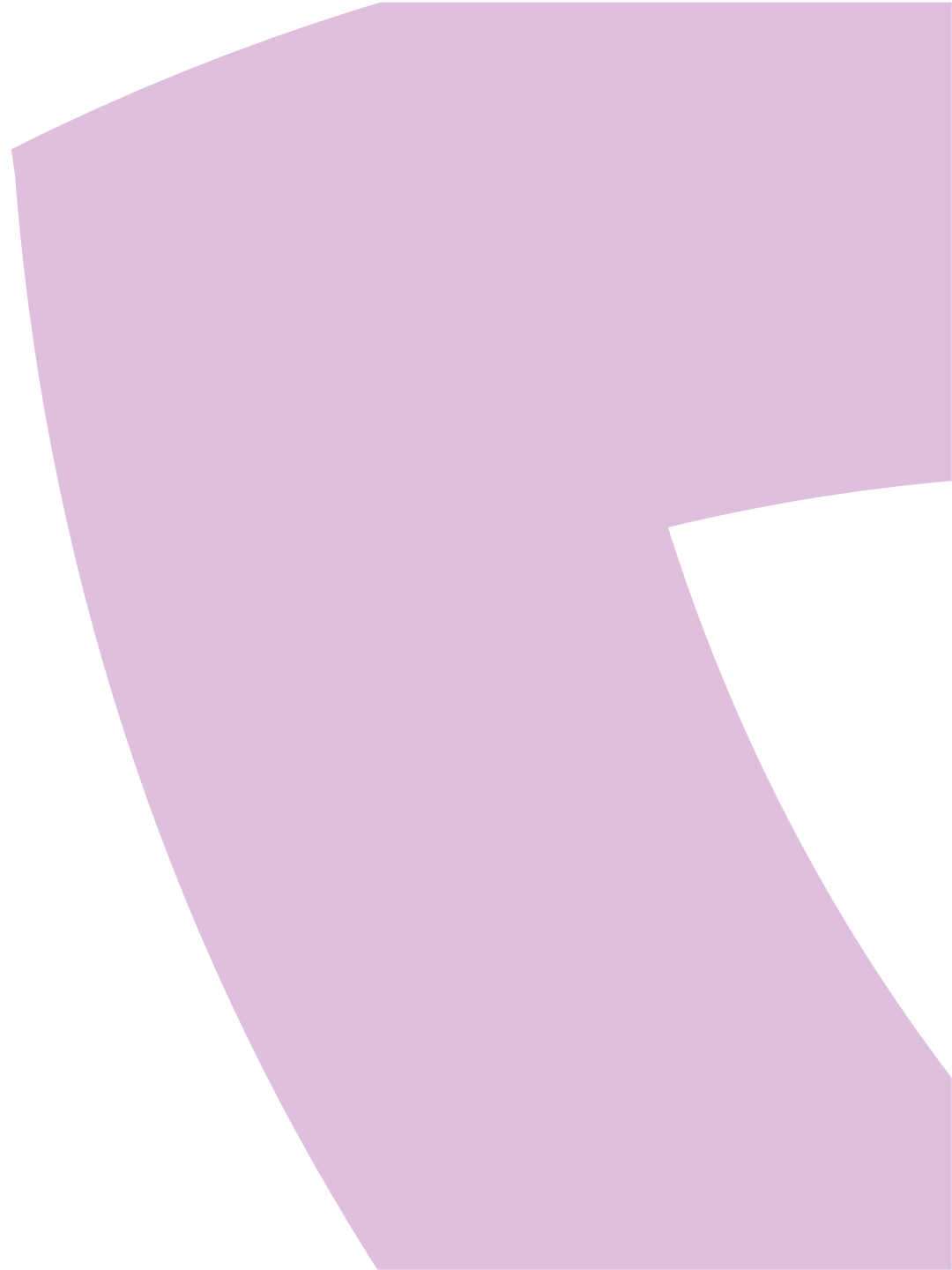
The Vendor should review the Application Status Report regularly. The Application Status Report will list all applications with activity during the reporting period.

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

A complete invoice consists of the following 16 data-fields, separated by 15 commas:

- 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 Home and Community Care Support Services (HCCSS)
- 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 uploaded and an error is noted in the vendor report the next day.
- 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 maximum of 90 days.
- An invoice with a delivery date or service end 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 end 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”** – Occurs where the invoice cannot be processed due to errors.
- **“Invoice Deleted”** – Occurs where an invoice that was “on hold” due to errors has been deleted by the system due to not being corrected within the 90-day window.

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
<p>Client is receiving Professional Services through Home and Community Care Services (HCCSS) as of the Service Start Date and is eligible for 100% funding.</p>	<p>Re-invoice for 100% funding using a unique Invoice Number. Most recent status update available indicates that client is receiving professional services through HCCSS and is therefore eligible for 100% funding. HCCSS services are temporary and subject to change.</p>
<p>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.</p>	<p>Vendor must provide proof that the client was not in hospital during the service period.</p>
<p>Incorrect Service period. Service end Date is after Home Oxygen Therapy Discontinued Date.</p>	<p>The service has been discontinued and a new application must be submitted for the client.</p>
<p>ADP Device Code on the invoice does not belong to the approved device type.</p>	<p>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.</p>

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 Assistive Devices Program \(ontario.ca\)](#)
- [Oxygen Therapy Policy and Administration Manual \(ontario.ca\)](#)
- [Application for Funding Home Oxygen Therapy - Forms - Central Forms Repository \(CFR\) \(gov.on.ca\)](#)

Contact Information



Program Contact Information

ADP Website:

[General Public Website](#)

[Health Professionals Website](#)

Mailing Address:

Program Coordinator, Home Oxygen Therapy

Assistive Devices Program

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Toll Free TTY: 1-800-387-5559