Assistive Devices Funding Program (ADFP)
APPLICATION FORM 2026

Ontario Federation for Cerebral Palsy

FOR OFFICE USE ONLY

Date Received _____

File Number _____

Please print in pen.

Note: The Assistive Devices Funding Program is only available to Individual Members of the Ontario Federation for Cerebral Palsy.

Indicate if you are an Individual Member.

Yes: _____ No: _____

PLEASE NOTE: INCOMPLETE APPLICATION PACKAGES WILL NOT BE PROCESSED FOR FUNDING. ONE ATTEMPT WILL BE MADE TO SECURE MISSING INFORMATION.

Application Date _____

Individual Member Number: _____

Please review the guidelines carefully before submitting your application.

APPLICANT INFORMATION

Name (who equipment is for): _____

First Name Last Name

Date of Birth: _____

Year / Month / Day

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: _____

Name of designated contact person to assist with communication/translation regarding processing of application if needed (optional):

Contact Name:_____

Relationship to applicant: _____

Contact Phone:_____

Contact 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 $ _____

An item that has been ordered or received does not guarantee approval of funding from this program.

Documentation Required: Health Professional current rationale letter for all items. If requested item is covered by ADP Ministry of Health and Long-Term Care, please have your health professional complete enclosed OFCP ADP Approval Confirmation Sheet or provide Ministry of Health ADP Approval Confirmation Sheet and submit with application.

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

NOTE: If you are requesting funding assistance for more than one piece of equipment/item/material please use additional pages.

Other Funding you have accessed: **OFCP requires a copy of written response for funding approved or denied which you received from the Ontario Ministry of Health – ADP, ODSP and/or Assistance for Children with Severe Disabilities Program for the requested item prior to submitting your application to OFCP. OFCP requires that you attach written response to support your OFCP ADFP funding applications.**

Please indicate which (if any) of the provincial programs you are receiving.

☐ Ontario Disability Support Program (ODSP)

☐ Ontario Works

☐ Assistance for Children with Severe Disability (ACSD)

☐ City of Toronto Hardship Fund ☐ None of these

Please check which funding sources you have already applied to:

	Applied	Not Applicable	Approved		Response
			YES	NO	Received in Writing
Ontario Disability Support Program (ODSP)	☐	☐	☐	☐	☐
Ontario Works	☐	☐	☐	☐	☐
Local City Social Services	☐	☐	☐	☐	☐
Assistance for Children with Severe Disability (ACSD)	☐	☐	☐	☐	☐
City of Toronto Hardship Fund	☐	☐	☐	☐	☐
Community Agencies	☐	☐	☐	☐	☐
Private Insurance	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

ASSISTIVE DEVICES FUNDING PROGRAM

Complete the calculation box below which applies to your request

Purchase Equipment/Item/Material - Calculation of Request for Financial Assistance

A) Estimated Cost of Equipment/Item/Material
(Excluding Labour / Installation)
$ _____
Preferred Vendor Quote

B) ADP Approved Amount
$ _____
Approved Amount

C) Other Funding Obtained

Agency _____
$ _____
Amount (attach letter if applicable)

Agency _____
$ _____
Amount (attach letter if applicable)

Agency _____
$ _____
Amount (attach letter if applicable)

D) Total Remaining
$ _____
A - B - C = D

TOTAL REQUESTED FROM OFCP
(Including all items)
$ _____
(25% of total cost up to $2000)

NOTE: If you are requesting funding assistance for more than one piece of equipment/item/material please use additional pages.

When was the last time you received funding from ADFP? _____

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 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. Approval of this application in this funding year does not guarantee approval in concurrent years.

By providing your signature below, as the applicant or applicant guardian, you are giving permission to OFCP staff to process your application accordingly and will indicate that you have read the ADFP guidelines and application.

Signature: _____ Date: _____

Year / Month / Day

Relationship to Applicant (if applicable): _____

Please ensure all information and supporting documentation are provided. If any information is missing or the application is incomplete, the applicant or primary contact person will be notified for completion and submission of missing information.

If we do not hear from the applicant within three weeks the application will no longer be active

If you require additional information, or require assistance completing this application, or have any questions please contact the Ontario Federation for Cerebral Palsy

416-936-6007
or toll free 1-877-244-9686 ext: 221
Email: funding@ofcp.ca
Website: www.ofcp.ca

Return the completed form by email to funding@ofcp.ca

ASSISTIVE DEVICES FUNDING PROGRAM

OFCP 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

Revised Feb 2026