Alberta Government

Prosthetic and Orthotic Device Validation Certificate

Classification: Protected A (when completed)

Alberta Aids to Daily Living (AADL) Program

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the *Health Information Act*, sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act* (FOIP) and the Alberta Aids to Daily Living and Extended Health Benefits Regulations for the purpose of obtaining an AADL benefit. If you have any questions about the collection of this information, you can contact the Alberta Aids to Daily Living Program at TELUS House 13th Floor, 10020 100 Street NW, Edmonton, AB T5J 0N3; Telephone: 780-427-0731, Fax: 780-422-0968 or 780-424-0432.

Client Section - To be completed by the Client:

Instructions to Client/Client Guardian/Legal Representative

Following review and discussion of this document with your Prosthetist/Orthotist, please:

1. Sign and date the applicable section of this form to verify that specified requirements have been reviewed and acknowledged.
2. Obtain a signed and completed copy of this form for your records.

Important: DO NOT sign this form until you have discussed **ANY/ALL** concerns regarding your AADL Program funded prosthetic/orthotic device(s). If you are *unable* to sign this form, contact Alberta Blue Cross.

Section 1: Selection and agreement to the provision of AADL Program funded prosthetic/orthotic device(s)

I, _____ confirm by my signature, that:
(Name in Full - Client/Client Guardian/Legal Representative)

☐ The AADL Program cost-share requirement has been discussed with me, and I am aware that costs which exceed the cost-share applicable AADL program maximum funding limits are not covered by the AADL Program and are therefore my financial responsibility.

☐ I have selected and agree to the provision of the following AADL Program funded prosthetic/orthotic device(s) following consultation with my Prosthetist/Orthotist.

_____

_____

_____

_____

(Description of prosthetic/orthotic device(s) which apply to the authorization number herein below)

☐ I acknowledge that in order to change my Prosthetist/Orthotist for AADL Program funded prosthetic/orthotic device(s), a transfer of care must be established. The AADL Program does **not** provide duplicate benefit funding.

_____ _____

(Consultation Date) (Signature - Client/Client Guardian/Legal Representative)

Section 2: Fitting, trial, and receipt of my AADL Program funded prosthetic/orthotic device(s)

I, _____ confirm by my signature, that:
(Name in Full - Client/Client Guardian/Legal Representative)

- ☐ My Prosthetist/Orthotist has fitted me with the AADL Program funded prosthetic/orthotic device(s) that I had selected and agreed to the provision of, and that I have trialed the associated AADL Program funded prosthetic/orthotic device(s).
- ☐ I acknowledge that ongoing adjustment(s) and/or modification(s) may be required to maintain a suitable fit.
- ☐ I acknowledge that I am responsible for all facets of the care and maintenance of my AADL Program funded prosthetic/orthotic device(s), which includes but is not limited to the responsibility to obtain insurance to replace my AADL Program funded prosthetic/orthotic device(s) especially in the event that it is lost, stolen, damaged, and/or for circumstances which are excluded from the scope of coverage of applicable manufacturer's warranties.
- ☐ I acknowledge that I am not permitted to modify, adjust or repair my AADL Program funded prosthetic/orthotic device(s), and therefore agree to consult with my Prosthetist/Orthotist when these services are required.
- ☐ I acknowledge that there are AADL Program quantity and frequency funding limits associated with my AADL Program funded prosthetic/orthotic device(s).
- ☐ I have received my prosthetic/orthotic device(s) and accompanying Alberta Blue Cross Patient Claim Statement(s) indicating the AADL Program contribution and client cost-share portion (where applicable).

_____ _____

(Date prosthetic/orthotic device(s) received) (Signature - Client/Client Guardian/Legal Representative)

Specialty Assessor/Supplier Section: To be completed by the Specialty Assessor/Supplier

The following information to which this validation certificate refers must be specified below:	
Authorization Number:	
Client Name:	
Client PHN:	
Vendor Name:	
Vendor Address:	