Alberta Government

Client Declaration Form

Protected A (when completed)

Alberta Aids to Daily Living 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

You must indicate the online authorization number to which this client declaration refers:

Authorization Number ____________________

TERMS AND CONDITIONS

1. This declaration must be completed and signed before any order can be placed. A copy must be kept on file at the **specialty assessor/authorizer site**.
2. If the client is unable to sign, please provide the name and phone number of the individual who is financially responsible for this client (Minor: Parent/Legal Guardian. Adult: Informal Trustee/Enduring Power of Attorney/Legal Trustee).

Client Declaration

I have reviewed my basic medical needs with a Specialty Assessor/Authorizer. I understand that if I do not qualify for Cost-Share Exemption (CSE), I will be required to pay 25% of the cost of my authorized benefits, to a maximum of $500 per family, per benefit year, and AADL will pay 75% of the authorized benefits. If I choose to upgrade, I am responsible for any cost exceeding AADL's price maximum. Upgrade costs are not included in the cost-share calculation.
Cost-share and any costs exceeding AADL's price maximum are payable directly to the vendor, not refundable under any circumstances, and not applicable to respiratory benefits.

Other Program Eligibility

I acknowledge that I am not eligible for the same or similar benefit through any of the following programs: First Nations and Inuit Health Branch; *Non-Insured Health Benefits Program; Workers Compensation Act; Department of Veterans' Affairs Act* (Canada) A Clients; and Federal Programs such as the RCMP, Penitentiaries and Armed Forces. I may not be eligible for this or a similar benefit if I have private insurance. I understand that it is my responsibility to ensure that the equipment is properly maintained and cared for. AADL may pay for selected repairs on approved government-owned equipment when provided through an AADL provider. AADL will not replace equipment or supplies that are lost, stolen or damaged due to misuse, or modifications made without AADL approval. Private insurance is recommended for protection against loss of equipment.

Collection of Personal Information

I understand that my personal information, including information about my health, is required to verify my eligibility for AADL program benefit(s), to arrange for benefit(s) to be provided to me and to enable AADL to pay for the benefit(s).
I consent to having information required for the above purpose sent by a health professional, authorized by AADL, to AADL and to a vendor of AADL benefit(s), for the provision and billing of the benefit(s). The information may be sent either by mail or electronically.
I understand that if I have any concerns regarding this collection of personal information, I should contact:
Information and Training Coordinator, AADL Program, Alberta Health
780-422-6871 or Telus House, 13th Floor, 10020 100 Street NW, Edmonton, AB T5J 0N3.

- I have read and understand the Terms and Conditions above.
- I understand this Client Declaration must be completed and signed before any order can be placed.

Note: If the client is unable to sign, provide the name and phone number of the individual who is financially responsible for this client (Minor: Parent/Legal Guardian, Adult: Informal Trustee/Enduring Power of Attorney/Legal Trustee). This individual is also required to sign and print their name on this form on behalf of the client.

Signature of Client/Individual for client ____________________ Name (Please PRINT) ____________________ Relationship to Client ____________________

Date ____________________ Phone Number (if not client) ____________________

Please check off the Yes or No box on the bottom of this form. If the client is unable to check off the box, the individual signing on behalf of the client must do so.
I consent to the use of my personal information for quality monitoring and program improvement, which may include telephone, mail, or web-based surveys. All personal information will be protected in accordance with the provisions in Alberta's *Health Act* and *Freedom of Information and Protection of Privacy Act* (FOIP).

☐ Yes ☐ No

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