Ministry of Social Development and Poverty Reduction

Breathing Device Request and Justification

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act.* The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act.* Any questions about this information should be directed to your local Employment and Assistance Office or by calling 1-866-866-0800.

Program Objective: To provide the least expensive, most appropriate medical equipment to meet a medically essential need. Full details on eligibility, including Life Threatening Health Need criteria can be found on the ministry's BC Employment & Assistance Policy & Procedure Manual at:
https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual

Forms Instructions: (see page 2 for Detailed Instructions and Required Documentation)
Section 1: to be completed by the applicant (e.g. the client). Section 1 is completed for all requests, *unless otherwise noted in Detailed Instructions.*
Section 2: to be completed by Medical Practitioner or Nurse Practitioner, or attach written prescription.
Section 3: to be completed by a Respiratory Therapist providing detailed specifications and functional assessment concerning the breathing device requested

Life Threatening Health Need: Financial eligibility must be established for LTHN; apply at: **https://myselfserve.gov.bc.ca/**

Section 1 - Client Information

Client Surname	Client Given Name	Telephone or Message	Birth Date (YYYY-MMM-DD)	Personal Health Number

Client Street Address (If Residential Care Facility, Name of Facility)	City/Town	Postal Code

Please list and describe any additional resources that could assist in meeting your medical needs (for example: ICBC, WorksafeBC, Veterans Affairs, Non-Insured Health Benefits (NIHB), private insurance).

I hereby give my permission for any Medical Practitioner or Nurse Practitioner, evaluating health professional, hospital or agency to give any medical information relevant to this application to the Ministry of Social Development and Poverty Reduction and service provider. I give my permission for the Ministry of Social Development and Poverty Reduction to discuss this request with the evaluating professionals and service provider. The breathing device recommended has been described to me and I agree with the recommendations.

Client Signature	Date Signed (YYYY-MMM-DD)

Section 2 - Medical Practitioner or Nurse Practitioner Recommendation
(Complete Section or Attach Prescription)

Describe the medical condition of your patient (Please Print). *If request is for life threatening health need please describe in detail.*

What type of breathing device is recommended? (Please Print)

Signature of Medical Practitioner Or Nurse Practitioner	Date Signed (YYYY-MMM-DD)

Print Name	Phone Number	Fax Number

Position/Title	Professional Registration Number

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Section 3 - Assessment (To be completed by a Respiratory Therapist only)

Important: Please attach a detailed quote

Please describe how the breathing device will meet applicant's medical needs (Please Print).

Signature of Person Providing Clinical Treatment/Respiratory Therapist	Date Signed (YYYY-MMM-DD)

Print Name	Phone Number

Professional Registration Number

Detailed Instructions and Required Documentation

CPAP/BiPAP Trial

- Complete Sections 1, 2 and 3; and
- Diagnostic Sleep Tests (e.g. overnight oximetry on room air, diagnostic polysomnogram); and
- Quote from contracted supplier for trial/rental of CPAP/BiPAP.

CPAP/BiPAP Buyout

- Therapeutic sleep test (e.g. overnight oximetry on CPAP or therapeutic polysomnogram); and
- Compliance report; and
- Quote from contracted supplier for buyout of CPAP/BiPAP.

Supplies (Masks/Tubing/Filters) **** No form needed if Ministry has previously funded CPAP***

- Quote from contracted supplier only

Previously Non Funded or Replacement Device

- Complete Sections 1, 2 and 3; and
- Overnight oximetry on room air, oximetry on CPAP and compliance download; and
- Quote from contracted supplier

Percussors

- Complete Sections 1 and 2 (or provide a written assessment from Occupational or Physical therapist); and
- Quote from supplier

Breathing Devices such as: Inhaler, Medical Humidifier, Nebulizer or Suction Machines

- Complete Sections 1 and 2 (or a written prescription from Medical Practitioner or Nurse Practitioner with diagnosis and detailed medical justification); and
- Quote from supplier ****Only required for Medical Humidifier***

FAX COMPLETED FORM TO: 1-855-771-8785