



Society For Manitobans With Disabilities
Wheelchair Services

1111 Winnipeg Avenue, Winnipeg, Manitoba R3E 0S3
Ph: (204) 975-3250 Fax: (204) 975-3240 Toll Free: 1-800-836-5551

POWER WHEELCHAIR APPLICATION

Type of Application: () Provision of power wheelchair
() Repairs to own power wheelchair - Chair has been pre-inspected by SMD technician for eligibility

Please Type or Print - Incomplete or Illegible Forms will be returned.

SECTION A

1. Name (Surname) (First Name)

2. Address: (Street or Box number) (City/Town)

Postal Code: Telephone #:

If box #, location of residence:

3. Date of Birth: Year Month Day MHSC #: PHIN #:

4. Next of Kin or Contact Person:

Relationship: Telephone #:

Mailing Address: (Street or Box number) (City/Town)

Postal Code:

5. Is applicant covered by any of the following funding sources?

• Employment and Income Assistance Yes No

District Office Fax # File #

• Medical Services Yes No

Band Name Treaty #

Physician's name (print) Physician's signature

Physician's 5 digit registration #

• MPI Yes No

• WCB Yes No

• DVA Yes No A coverage B coverage

DVA Worker Phone #

• Other:

6. I hereby make application to the Manitoba Wheelchair Program and authorize the release of information required with respect to this application.

Signature: () Applicant

() Parent

Date: () Guardian



EQUIPMENT LOAN AGREEMENT

The equipment is the property of the Winnipeg Regional Health Authority (WRHA) and is loaned through the Manitoba Wheelchair Program, operated by the Society for Manitobans with Disabilities Inc.

I accept the loan of the equipment on the following terms:

- I am only entitled to use the equipment while I am a full time resident of Manitoba.
• I will only use the equipment for my personal mobility.
• I will use and store the equipment carefully to avoid damage or loss.
• I will not remove the permanent identification tag attached to the equipment.
• I will follow the preventative maintenance program and make the equipment available for servicing.
• If I move within Manitoba, I will report my new address and telephone number to the Manitoba Wheelchair Program no later than 30 days following my move.
• If I enter a personal care home in Manitoba, I may continue to use the equipment only if I have been a client of the Manitoba Wheelchair Program for the 6 months before I enter the personal care home.
• I will not sell, loan or allow any other person to use the equipment.
• The WRHA will have no responsibility for equipment repairs outside of Manitoba.
• The WRHA may re-assess my need for the equipment at any time.
• I will promptly return the equipment to the Manitoba Wheelchair Program if I am no longer eligible under the Manitoba Wheelchair Program or if I no longer need the equipment or if I do not observe the terms of this agreement.
• If the equipment is not returned, I will pay the cost to replace the equipment.
• This agreement binds my estate.

If I am a minor, I agree this is a contract to supply a necessary wheelchair and is binding on me when I reach 18. If I am signing on behalf of a minor, both the minor and I are individually liable for these obligations.

I have read and understand the terms printed on this form. I am legally bound by the terms and I accept the loan of the equipment on these terms. As the applicant, I have been actively involved in this assessment and agree to the information provided in this application.

Signed by client: _____ Date: _____

Signed by representative/legal guardian: _____ Date: _____

Relationship to client: _____

Witness Signature: _____ Witness Name: _____

PRIVACY STATEMENT: The personal Health information on this application is treated in compliance with the "Personal Information Protection and Electronic Documents Act". Should you be approved for a power wheelchair, you will receive a brochure summarizing SMD Services' privacy policy along with your wheelchair notification letter. Please review the policy summary when you receive it, as it is our commitment to your privacy. SMD promises to safeguard your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.



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SECTION B: MEDICAL INFORMATION

Sections B1 and B2 must be completed by a physician for NIHB and EIA in institution applications

Section B 1 must completed by an occupational therapist or a physiotherapist for all WRHA applications

and Sections C– I must be completed by an occupational therapist or a physiotherapist for all applications

Please Type or Print Legibly

B.1 Client Name: _____ MHSC #: _____

1. a) Primary diagnosis: _____

b) Date of onset: _____

c) Is a change in medical condition expected: (explain) _____

d) Other relevant conditions: _____

B. 2 It is my opinion that provision of a power wheelchair is required in order to improve this applicant's functional status. Yes No

Physician's Signature: _____ Registration # _____

Name of Physician: _____ Date: _____

(Please print or type)

Address: _____ City/Town: _____

Postal Code: _____ Telephone Number: _____

SECTION C: CURRENT MOBILITY

1. **If applicant is unable to walk, check here and complete 1 c) only.
If applicant is walking, complete 1 a) – 1 c).**

a) **Indoors ambulation:**

Devices used: None Cane Crutches Walker Other _____ (Specify)

Describe gait: Independent Standby assist required Supportive assist required

Approximate distance of **independent ambulation** indoors: _____ feet/meters (circle one)

Comments: _____

b) **Outdoors ambulation:**

Devices used: None Cane Crutches Walker Other _____ (Specify)

Describe gait: Independent Standby assist required Supportive assist required

Approximate distance of **independent ambulation** outdoors: _____ feet/meters (circle one)

Comments: _____

c) **To what extent are limitations in ambulation affected by the following?**

	N/A	Mildly	Moderately	Severely
Decreased strength: U/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased ROM: U/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Standing Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Section C: Current Mobility (continued)

2. If applicant does not use a manual wheelchair, check here and complete 2 d) only. If applicant uses a manual wheelchair, please complete 2 a) – 2d).

a) **Make and model** _____

Date obtained: _____ From whom: _____

b) **Indoor use:** Describe method: Independent Requires assist Dependent

Approximate distance of **independent propulsion** indoors: _____ feet/meters

Comments: _____

c) **Outdoor use:** Describe method: Independent Requires assist Dependent

Approximate distance of **independent propulsion** outdoors: _____ feet/meters

Comments: _____

d) **To what extent are limitations in manual wheelchair propulsion affected by the following?**

	N/A	Mildly	Moderately	Severely
Decreased strength: U/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased ROM: U/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L/Es	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Sitting Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited Endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

3. **Although the Manitoba Community Wheelchair Program does not provide scooters, information regarding the suitability of same for applicant is relevant. Would this applicant be able to safely operate a scooter?**

Yes No

E.g.) comment on ability to transfer to scooter, sitting balance on scooter and ability to drive/steer the scooter.

4. **Does the applicant use a privately owned power mobility device? Yes No**

If yes, circle descriptor of privately owned power mobility aid: Scooter Power Wheelchair

Make and model: _____

Date obtained: _____ From Whom: _____

Comment on the suitability of current power mobility aid: _____

SECTION D: LIFESTYLE / USAGE PROFILE

1. It is anticipated that the applicant will use the power wheelchair:
Mostly in the community Mostly inside home/suite Inside home/suite & community

2. It is anticipated that a power wheelchair will be used:
As the primary method of mobility Daily basis 2-3 times per week Weekly

Comments: _____

3. Usage Profile

The applicant **REQUIRES** power mobility for the following activities: Describe why/how and include frequency of these activities

- Feeding _____
- Dressing _____
- Grooming _____
- Toileting _____
- Bathing _____
- Meal Preparation _____
- Grocery Shopping _____
- Managing Finances _____
- Light Cleaning _____
- Heavy Cleaning _____
- Laundry _____

4. Other activities applicant is currently involved in, or would participate in, which require the use of power mobility for independent involvement- be specific and include frequency:

5. Describe applicant's child care responsibilities: N/A _____

How would a power chair facilitate participation in child care activities? _____

6. Is the applicant currently employed? Yes No

Position held: _____
Full time Part time Hours per day or week _____ day/ week (circle one)

How would a power chair facilitate employment? _____

7. Is the applicant presently enrolled in an education program? Yes No

Institution applicant attending: _____

Program: _____

Full time Part time Hours per day or week: _____ day/week (circle one)

How would a power chair facilitate participation in education program? _____

8. Is the applicant presently involved in volunteer activity? Yes No

Organization: _____

Full time Part time Include the number of hours per day or week _____ day/week (circle one)

How would a power chair facilitate participation in volunteer activities? _____

9. If this applicant has regularly scheduled medical appointments please qualify by describing the frequency of these appointments and the time spent at the appointments. Would a power wheelchair facilitate/be used at these appointments? Describe N/A

10. Does the applicant participate in recreational activities/socialization? Yes No

(This would include participation in activities that client does in home and community with family/friends)

1. Recreation/Activity _____ Frequency _____

2. Recreation/Activity _____ Frequency _____

3. Recreation/Activity _____ Frequency _____

4. Day Program _____ Frequency _____

How would a power chair affect/facilitate participation in these activities? _____

11. Approximate the total number of hours/day engaged in the above power mobility (#1-10) related activities:

SECTION E: SUPPORT SYSTEM

1. Who does client live with: Alone Spouse/Partner Parents Children Roommate
Attendant Group Home Other Facility

2. What current mobility assistance is required from a caregiver/others? _____

3. What would be the effect on these supports if applicant used a power wheelchair? _____

4. If applicant does not have a support system to assist with mobility, describe the impact that a power wheelchair would have on client's level of independence.

SECTION F: PHYSICAL ENVIRONMENT (NOTE: A HOME VISIT MUST BE COMPLETED)

1. a) Indicate setting of client's home: Rural Urban

b) Indicate the presence of the following (Check all that apply):

Paved streets Paved sidewalks Gravel roads Gravel sidewalks No sidewalks Curb cuts

2. a) Describe client's living environment:

Private home: owned rented Group Home: Long Term Care Facility:
Apartment/Condo: owned rented Other: _____

b) Home Accessibility:

Entrance has a lift or ramp or level entrance Lift/ramp has safe railing

Doorway widths: Main entrance: _____ Bathroom: _____ Bedroom: _____
Kitchen: _____ Living Room: _____ Other: _____

Power Chair can maneuver through/in: Bedroom Bathroom Kitchen Living Room
Hallways Other _____

Will/Do any of the following cause difficulties or safety problems:

Carpets Tight corners Elevators Stairs Bathroom size
Narrow halls Open stairs others _____

Who did a home visit to verify this information? _____

If residence is not fully accessible, describe plans for making it so: _____

c) Is a move anticipated? No Yes Is the new residence accessible? Yes No

Comments: _____

3. Would applicant, parent/guardian, agree to make the required modifications to facilitate the use of a power wheelchair? Yes No

Comments: _____

4. Does the applicant have a safe (locked) and suitable (dry and warm) location in which to store the power wheelchair? Yes No

Where: _____

5. a) Is the applicant's school/work environment compatible with the use of a power wheelchair?

Yes No N/A

b) Would employer/school, agree to make the required modifications to facilitate the use of a power wheelchair? Yes No N/A

Comments: _____

6. Are the Community/Leisure/Recreational environments compatible with the use of a power wheelchair (E.g. public buildings, businesses, churches, etc.) Yes No

Comments: _____

7. Is applicant able to transport a power wheelchair?

Yes Van with lift Accessible transit Other _____

No Please describe transportation plans: _____

SECTION G: POWER WHEELCHAIR ASSESSMENT
(MUST BE COMPLETED AS PART OF THE APPLICATION PROCESS)

1. During assessment in power wheelchair, can the applicant do the following?

	Yes	No
Move wheelchair in at least one direction.	<input type="checkbox"/>	<input type="checkbox"/>
Move wheelchair forward.	<input type="checkbox"/>	<input type="checkbox"/>
Stop within 5 seconds on request.	<input type="checkbox"/>	<input type="checkbox"/>
Move toward an object and stop appropriately before hitting object.	<input type="checkbox"/>	<input type="checkbox"/>
Keep head up and attend to surroundings.	<input type="checkbox"/>	<input type="checkbox"/>
Drive around obstacles	<input type="checkbox"/>	<input type="checkbox"/>
Drive through doorways	<input type="checkbox"/>	<input type="checkbox"/>
Travel along a narrow hallway	<input type="checkbox"/>	<input type="checkbox"/>
Turn around inside a small room and exit the room	<input type="checkbox"/>	<input type="checkbox"/>
Reverse safely	<input type="checkbox"/>	<input type="checkbox"/>

Does the applicant

Have cognitive skills for safety?	<input type="checkbox"/>	<input type="checkbox"/>
Have perceptual skills for safety?	<input type="checkbox"/>	<input type="checkbox"/>
Have adequate vision skills to be safe and independent?	<input type="checkbox"/>	<input type="checkbox"/>
Pay visual attention to environment?	<input type="checkbox"/>	<input type="checkbox"/>
Have adequate hearing skills to be safe and independent?	<input type="checkbox"/>	<input type="checkbox"/>
Display speed control in driving?	<input type="checkbox"/>	<input type="checkbox"/>
Display directional control in driving?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to focus on one activity for 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to drive in a structured environment?	<input type="checkbox"/>	<input type="checkbox"/>
Have the ability to drive in an unstructured environment?	<input type="checkbox"/>	<input type="checkbox"/>

2. Can the applicant use power mobility independently? Yes No If no, describe what supports are /supervision is needed. _____

3. Describe areas of difficulty most likely to impact on safe operation of a power wheelchair.

4. Is it likely that extensive training will be needed in order for client to safely use a power wheelchair?
Yes No

If yes, where would training occur? _____

SECTION H: SCRIPTER INFORMATION

Scripter's Name: _____ (Please print)

Designation: _____ Agency: _____

Address: _____

Postal Code: _____ Telephone: _____ Fax: _____

E-mail address: _____

It is my opinion that provision of a power wheelchair is the most appropriate means of improving this applicant's functional status. Yes No

Scripter's General Impressions: _____

Signature: _____ **Date:** _____

SECTION I: WHEELCHAIR SPECIFICS

Note: If midwheel drive power wheelchair is being requested, complete Mid Wheel Drive – Addendum to Power Wheelchair Application in lieu of this page.

1. **Applicant Information:** weight _____ lbs/kgs (circle one) height _____ inches/cm (circle one)

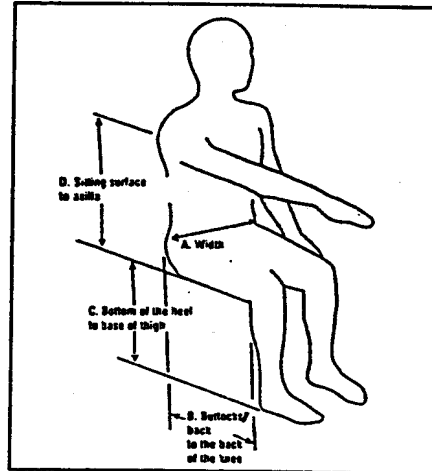
2. **Wheelchair dimensions:** Please consider client size, seating inserts, and functional usage of wheelchair when determining the wheelchair prescription. For example, the transfer method, wheelchair cushion, and applicant's height may all affect the recommended floor-to-seat height of the prescribed wheelchair.

Seat Width = Measure "A" _____ + (1" to 2") =

Back Height = Measure "D" _____
 - (2 to 3 if has good sitting balance) + (compressed height of cushion) =

Seat Depth = Measure "B" _____ - (2") =

Seat Height = Measure "C" _____
 + (2" to 3" for foot pedal clearance)
 - (compressed height of cushion) =



If available: **Seat angle** _____
Seat/back angle _____

3. **Wheelchair options:**

Armrests Full length Desk length
Leg rests Standard Right Left
 Elevating Right Left

Control: Joystick: Right Left
 Other: Please specify: _____

4. **Will it be necessary to fit or mount to the chair other devices related to any of the following? (Check all that apply).**

Communication Positioning Environmental
 Respiratory Seating None required

If yes, describe equipment needed (include information regarding intended supplier):

5. **Is it likely that specialty controls will be needed?** Yes No

If yes, please describe _____

6. **Is delivery to home address?** Yes No deliver to: _____

(Note: Wheelchair Services will deliver to ONE address only.)

7. **Battery information:** The WRHA Manitoba Wheelchair Program provides sealed (gel cell) batteries for power wheelchair users. These batteries require regular charging to ensure functional use and this is the responsibility of the consumer.

Who will perform battery maintenance? _____