SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax (204) 975-3240 Toll Free 1-800-836-5551

MANUAL WHEELCHAIR APPLICATION
CATEGORY 1A / 1B

Note: Illegible or incomplete application forms will be returned to the prescriber

****Applicants with EIA/NIHB Funding are only eligible for a Category 2A wheelchair (or higher) via SMD Wheelchair Services****

☐ **New Application** ☐ **Exchange Application**

Reason for Exchange: _____

Applicant will require the wheelchair: ☐ **More than 6 months** ☐ **Less than 6 months**

Check the box that is most applicable to the applicant

☐ **OCCASIONAL USER:** Can walk more than 80 feet / 25 meters with or without aid, requires wheelchair for long distances

☐ **PALLIATIVE:** When renting is not possible, a Category 1 wheelchair is available for persons considered at the end stage of a terminal illness.

If Palliative, please specify: ☐ **URGENT** (for palliative applicants who require the wheelchair full time)
☐ **REGULAR** (for palliative applicants who require the wheelchair part time)

DEMOGRAPHICS (PLEASE PRINT)

FIRST NAME	**LAST NAME**	
DATE OF BIRTH (MM/DD/YYYY)	**GENDER** male female	**PHIN**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

Residence is a PCH or institution: ☐ YES ☐ NO Applicant is paneled/ will be paneled to PCH: ☐ YES ☐ NO

Currently in hospital: ☐ YES ☐ NO Discharge Date: _____ Discharge Location: _____

Note: Prescribing therapist must inform SMD if there is a change in discharge location (i.e. PCH, Chronic Care)

NEXT OF KIN (MUST BE A MANITOBA RESIDENT)

FIRST NAME	**LAST NAME**	**RELATIONSHIP TO APPLICANT**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

PRESCRIBER - REGISTERED NURSE, PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT APPLICATIONS ACCEPTED

POSITION ☐ **OCCUPATIONAL THERAPIST** ☐ **PHYSIOTHERAPIST** ☐ **OTHER:** _____

FIRST NAME	**LAST NAME**	
ADDRESS	**CITY**	**POSTAL CODE**
EMAIL	**PHONE**	**FAX**

DIAGNOSIS AND/OR PRESENTING CONDITION(S) RELATED TO THE NEED FOR A WHEELCHAIR

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APPLICANT MEASUREMENTS

CURRENT WEIGHT: _____ lbs./ kg (circle one)	HEIGHT: _____ ft. in./ cm (circle one)

MEASUREMENTS	Information provided in this application must reflect applicant's current measurements	Measurement (inches)
	Hip Width: (straight line) or widest part of body in sitting	
	Thigh Length: (straight line) from back of buttocks to back of knee	
	Lower leg length: (straight line) from back of knee to bottom of heel	
	Back height: Sitting surface to axilla	

WHEELCHAIR PARAMETERS

WEIGHT CAPACITY	☐ **Standard** (up to 300lbs.)	☐ **Heavy Duty** (> 300lbs.,up to 450 lbs.)
	Up to 300 lbs. weight capacity	**450 lbs. weight capacity**
SEAT WIDTH	☐ **16"** ☐ **18"** ☐ **20"**	☐ **22"** ☐ **24"**
SEAT DEPTH	☐ **16"**	☐ **18"**
SEAT HEIGHT	☐ **17.75"** ☐ **19.75"**	☐ **21"**
BACK HEIGHT	☐ **16"**	☐ **16"**
FIXED HEIGHT ARMREST	☐ **Full length** ☐ **Desk length**	☐ **Full length** ☐ **Desk length**
LEG RESTS w/ composite footplates	☐ **70 degree** ☐ **Elevating**	☐ **70 degree** ☐ **Elevating**
TIRES	**Solid Rubber**	**Solid Rubber**
WHEEL LOCK EXTENSIONS	☐ **No** ☐ **Yes** ☐ **Right** ☐ **Left**	☐ **No** ☐ **Yes** ☐ **Right** ☐ **Left**

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **Anti-tippers are not available on Category 1A/ 1B wheelchairs**

☐ **Prescribed wheelchair will fit in applicant's home environment**

☐ **I have reviewed the SMD Equipment Loan Agreement with the Applicant and/or Representative**

☐ **The prescriber has verified the applicant is not eligible for EIA, NIHB, WCB, MPIC, Victim's Services funding and/or is not a ward of Child & Family Services**

_____ _____

Prescriber's Signature **Date**

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EQUIPMENT LOAN AGREEMENT

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

1. I am entitled to use the equipment while I am a full time resident of Manitoba. If I move outside of Manitoba, I will return the equipment before leaving the province or purchase the equipment.
2. If I move within Manitoba, I will promptly report my new address and telephone number to the Manitoba Wheelchair Program.
3. I will only use the equipment for my personal mobility.
4. I will not sell, loan or allow any other person to use the equipment.
5. I will store the equipment in a secure, heated and dry indoor space to avoid damage or loss. If the equipment is damaged or lost because of failure to comply with safe storage, I will be required to pay the cost of repair or replacement.
6. I am responsible to use the equipment with reasonable care, keep it clean and regularly maintained. If the equipment is damaged or lost due to misuse I will be required to pay the cost of repair or replacement. The MB Wheelchair Program recommends that the wheelchair be added to the client's homeowner's / tenant's insurance policy.
7. I will not remove the permanent identification sticker attached to the equipment.
8. I will make the equipment available for servicing as necessary.
9. The Manitoba Wheelchair Program will have no responsibility for equipment repairs outside of Manitoba.
10. 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 at least 6 months before admission to the Personal Care Home.
11. The Manitoba Wheelchair Program may re-assess my eligibility for the equipment at anytime.
12. I will promptly return the equipment to the Manitoba Wheelchair Program if I a) am no longer eligible under the Manitoba Wheelchair Program OR b) no longer need the equipment OR c) fail to observe the terms of this agreement. I recognize that taking care of the equipment and returning it when I no longer need it will benefit other people. If the equipment is not returned, I will pay the depreciated value to replace the equipment.
13. 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.

The personal Health Information on this application is treated in compliance with the "Personal Information Protection and Electronic Documents Act." In order to serve you better we may need to share your personal information with others. Most commonly these include medical professionals. SMD promises to treat your personal information in a secure and reasonable fashion while providing you with the highest level of professional service.

☐ **I have read and understand the terms of the above Equipment Loan Agreement. I am legally bound by the terms and accept the loan of the equipment on these terms.**

☐ **I authorize SMD Wheelchair Services to disclose my personal health information contained in my wheelchair Application to authorized personnel for the sole purpose of processing my wheelchair request**

Client Signature: _____ **Date:** _____

If client cannot write, a **LEGAL REPRESENTATIVE** may sign on behalf of the client below:

Name: _____ **Signature:** _____ **Relationship to Client:** _____

Witness Name: _____ **Witness Signature:** _____