

MANUAL WHEELCHAIR APPLICATION CATEGORY 2A

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

New Application

Exchange Application

Reason for Exchange: _____

PRIORITY LEVEL OF APPLICATION

Anticipated use of wheelchair: Temporary, less than 6 months Long Term/ Indefinite

REGULAR: Applicant requires the wheelchair part time and/or has a wheelchair on loan/rental for interim use

URGENT: Applicant requires the wheelchair full time and has no other means of mobility and/or is in hospital*.

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)

Delivery Instructions (if different than home address): _____

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: <input type="checkbox"/> YES <input type="checkbox"/> NO		Applicant is paneled/ will be paneled to PCH: <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

THIRD PARTY FUNDING INFORMATION (COMPLETE AREAS THAT APPLY)

EMPLOYMENT & INCOME ASSISTANCE **NON INSURED HEALTH BENEFITS**

Case Number: _____ **NIHB Loan Agreement attached**

10-digit number: _____

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

PRESCRIBER INFORMATION

OCCUPATIONAL THERAPIST **PHYSIOTHERAPIST** **OTHER:** _____

FIRST NAME	LAST NAME	FACILITY NAME
REGISTRATION #	PHONE	FAX
ADDRESS	CITY	POSTAL CODE
SIGNATURE: _____		DATE

ASSESSMENT FINDINGS: MEDICAL HISTORY

Medical Diagnoses AND Functional implications related to need for wheelchair:

PRESCRIPTION

2A: Breezy Easy Care 4000 Note: Applicant's weight must not exceed 250lbs.

ASSESSMENT FINDINGS: USAGE PROFILE & PROPULSION STATUS

<input type="checkbox"/> Part Time User (3-6 hours per day)		<input type="checkbox"/> Full Time User (6+ hours per day)
<input type="checkbox"/> Attendant Assist <i>(does not propel, pushed at all times)</i>	<input type="checkbox"/> Partially Independent <i>(Requires assist in some environments/ outdoors or for longer distances)</i>	<input type="checkbox"/> Independent <i>(propels independently in all environments)</i>

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

SEAT WIDTH	<input type="checkbox"/> 16"	<input type="checkbox"/> 18"	<input type="checkbox"/> 20"
SEAT DEPTH	<input type="checkbox"/> 16" <input type="checkbox"/> 18"	<input type="checkbox"/> 16" <input type="checkbox"/> 18"	<input type="checkbox"/> 18"
SEAT HEIGHT	<input type="checkbox"/> 17.75" <input type="checkbox"/> 19.75"	<input type="checkbox"/> 17.75" <input type="checkbox"/> 19.75"	<input type="checkbox"/> 19.75"
BACK HEIGHT	<input type="checkbox"/> 16" <input type="checkbox"/> 18"	<input type="checkbox"/> 16" <input type="checkbox"/> 18"	<input type="checkbox"/> 16" <input type="checkbox"/> 18"

WHEELCHAIR ACCESSORIES

HEIGHT ADJUSTABLE FLIP BACK ARMREST	LEG RESTS w/ composite footplates	WHEEL LOCK EXTENSIONS	ANTI-TIPPERS
<input type="checkbox"/> Full length <input type="checkbox"/> Desk length	<input type="checkbox"/> 70 degree <input type="checkbox"/> Elevating Justification:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> No <input type="checkbox"/> Yes Justification:

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

- Prescribed wheelchair will fit in applicant's home environment
- I have reviewed the SMD Equipment Loan Agreement with the Applicant and/or Representative

Prescriber's Signature _____ Date _____

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:** _____