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

POWER WHEELCHAIR APPLICATION
CATEGORY 5
PEDIATRIC AND ADULT

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

☐ **New Application** ☐ **Exchange Application**
Reason for Exchange: _____

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)

Delivery Instructions (if different than home address): _____

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**
Case Number**:** _____

☐ **NON INSURED HEALTH BENEFITS**
☐ **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**

MEDICAL DIAGNOSES AND FUNCTIONAL IMPLICATIONS REQUIRING USE OF POWER WHEELCHAIR

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ELIGIBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY

REQUIREMENT: □ Applicant is a full time user (6+ hours per day for school, recreation, ADL and IADL function).

REQUIREMENT: □ The applicant intends to use the power wheelchair inside their home as well as in the community.
Note: SMD will not provide power wheelchairs for community use only

REQUIREMENT: □ Home has an accessible entrance: (circle one) street level entrance ramp platform lift

Verified by: _____

□ An in-chair power wheelchair driving assessment was completed.

□ Applicant cannot propel a manual wheelchair independently to meet his/her basic and essential mobility requirements in their home.

□ Applications for a power wheelchair will not be considered within two years of receipt of a Category 3 or Category 4 wheelchair.

□ Applicant's home environment has been assessed by an Occupational Therapist (Date of assessment: _____)

□ The applicant can store the power wheelchair in an area that is: indoors, locked, heated and well-ventilated. (Note: Sheds and/or a detached garage are not considered a suitable storage area).

□ Applicant is capable of caring for a power wheelchair including daily battery charging and chair maintenance.

□ The applicant has sufficient judgment and cognitive capacity to safely and independently operate a power wheelchair.

□ Applicant has been informed that SMD Wheelchair Services will not supply a back-up manual chair.

□ Applicant has been informed SMD only provides ONE basic mobility device and any wheelchair previously on loan must be returned to SMD (if applicable).

□ Applicant has been informed the power wheelchair will require appropriate seating components that are NOT available through SMD.

PRESCRIPTION

MID WHEEL DRIVE	REAR WHEEL DRIVE	BARIATRIC MIDWHEEL DRIVE
□ Ped: Zippie Xperience2 (300lbs) □ Adult: Quickie Xperience2 (300lbs) □ Adult: Quickie Xperience2HD (400lbs)	□ Ped: Zippe Xplore2 (300lbs) □ Adult: Quickie Xplore2 (300lbs) □ Adult: Quickie Xplore2 HD (400lbs)	□ Adult: Quickie Xcel2 (550lbs)

□ ORDER FORM FOR SELECTED POWER WHEELCHAIR ATTACHED

RATIONALE FOR DRIVE WHEEL SELECTION:

POWER WHEELCHAIR DRIVING ASSESSMENT

IN-CHAIR DRIVING ASSESSMENT COMPLETED ON: _____ **by** _____
Date **Therapist Name**

POWER WHEELCHAIR USED FOR ASSESSMENT: _____ **ASSESSMENT LOCATION:** _____

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POWER WHEELCHAIR DRIVING SKILLS ASSESSMENT

SCORING GUIDE	**1**	CONSISTENTLY DEMONSTRATES SAFE OPERATION, INDEPENDENT WITH TASK, NO CONCERNS NOTED
	2	REQUIRES SEVERAL ATTEMPTS/PRACTICE TO COMPLETE TASK, VERBAL CUEING NEEDED; DISPLAYED NERVOUS TENDENCIES/HESITATION
	3	UNABLE TO COMPLETE TASK; DEMONSTRATED UNSAFE OPERATION
	4	NOT ASSESSED; PROVIDE REASON
	N/A	NOT APPLICABLE

DRIVING SKILL	SCORE	COMMENTS/ THERAPIST'S IMPRESSIONS
OPERATE ON/OFF SWITCH		
OPERATE SPEED CONTROL		
NAVIGATE THROUGH WIDE DOORWAY		
STOP & GO WITH CUEING		
STOP & GO (SELF INITIATED)		
RIGHT TURNS		
LEFT TURNS		
360°TURN (RIGHT & LEFT)		
NAVIGATE THROUGH NARROW DOORWAY		
ENTER AND EXIT ELEVATOR		
APPROACH A TABLE		
RECOGNIZE AND AVOID OBSTACLES		
UP/DOWN A RAMP		
SAFELY USE AUTOMATIC DOOR OPENER		
DRIVE ON PAVED SIDEWALK		
DRIVE ON UNEVEN TERRAIN/ ROUGH SURFACE		
CROSS STREET SAFELY, OBEYING TRAFFIC LIGHTS		
MANAGE 2" CURB		
DRIVE IN BUSY/UNSTRUCTURED AREAS		
CAN FOLLOW INSTRUCTIONS		
CAN PROBLEM SOLVE		
DEMONSTRATES AWARENESS OF THEIR SURROUNDINGS		

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FUNCTIONAL STATUS

TRANSFER STATUS	☐ **Independent**	☐ **With Assistance**	☐ **Mechanical Lift**
AMBULATION STATUS	☐ **Independent** **(Describe gait aid used)** **Approximate Distance:**	☐ **With assistance** **(Describe)** **Approximate Distance:**	☐ **Non-ambulatory*** **(Proceed to next section)**

DESCRIBE FACTORS THAT LIMIT OR NEGATIVELY IMPACT THE APPLICANT'S AMBULATION AND HOW A POWER WHEELCHAIR WILL ADDRESS THESE FUNCTIONAL CONCERNS:

CURRENT WHEELCHAIR / MOBILITY DEVICE

Make and Model: _____	**Year Obtained:**	**From:**

DESCRIBE FACTORS THAT LIMIT OR NEGATIVELY IMPACT APPLICANT'S ABILITY TO USE THEIR CURRENT MOBILITY DEVICE:

DESCRIBE WHY A MANUAL WHEELCHAIR IS NOT SUITABLE FOR THIS APPLICANT:

SUPPORT SYSTEM

APPLICANT LIVES: ☐ **ALONE** ☐ **WITH SPOUSE/PARTNER** ☐ **WITH CHILDREN** ☐ **WITH ATTENDANT**

DOES THE APPLICANT RECEIVE HOME CARE SUPPORT? ☐ **NO** ☐ **YES**
If Yes, Describe:

DESCRIBE THE LEVEL OF MOBILITY ASSISTANCE CURRENTLY PROVIDED BY SUPPORTS LISTED ABOVE

DESCRIBE THE IMPACT A POWER WHEELCHAIR WOULD HAVE ON THESE SUPPORTS

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FUNCTIONAL CONSIDERATIONS

DESCRIBE THE SELF-CARE TASKS CURRENTLY COMPLETED AT A WHEELCHAIR LEVEL AND HOW A POWER WHEELCHAIR WILL ENHANCE THE APPLICANT'S INDEPENDENCE WITH THESE TASKS:

DESCRIBE ANY COMMUNITY OR HOME MANAGEMENT TASKS THE APPLICANT MUST COMPLETE AND DESCRIBE HOW A POWER WHEELCHAIR WILL ENHANCE THEIR INDEPENENCE WITH THESE TASKS: *(Include usage information related to employment, school, recreational or leisure activities)*

HOME ASSESSMENT

DESCRIBE APPLICANT'S CURRENT RESIDENCE: *Select all that apply*

□ URBAN □ RURAL	□ DETACHED HOUSE □ APARTMENT/ CONDO	□ OWNED □ RENTAL	□ INDEPENDENT □ GROUP HOME	□ ASSISTED LIVING □ SUPPORTIVE HOUSING	□ PCH/ CHRONIC CARE FACILITY

□ **PRESCRIBER HAS DETERMINED APPLICANT'S SCHOOL/WORK ENVIRONMENT(S) ARE ACCESSIBLE WITH USE OF POWER WHEELCHAIR**

ACCESSIBILITY CONSIDERATIONS & DOORWAY MEASUREMENTS

A HOME VISIT/ ACCESSIBILITY ASSESSMENT COMPLETED **WITH** POWER WHEELCHAIR IN THE APPLICANT'S HOME □ YES □ NO

	Measurement	Access Issue Identified? (circle one)	Plans to ensure accessibility
Front Entrance		Yes / No	
Bathroom		Yes / No	
Bedroom		Yes / No	
Living Room		Yes / No	
Kitchen		Yes / No	
Hallway		Yes / No	
Elevator		Yes / No	
Ramp width *(if applicable)*			

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APPLICANT MEASUREMENTS – INFORMATION PROVIDED MUST REFLECT APPLICANT'S CURRENT MEASUREMENTS

CURRENT WEIGHT: _____ lbs/ kg (circle one)	HEIGHT: _____ ft. in./ cm (circle one)	
	Measurement (inches)	**Recommended Wheelchair Dimensions (inches)**
Hip Width: (straight line) or widest part of body in sitting		**Seat Width:**
Thigh Length: (straight line) from back of buttocks to back of knee		**Seat Depth:**
Lower leg length: (straight line) from back of knee to bottom of heel		**Seat to Floor Height:**
Back height: Sitting surface to axilla		**Back Height:**

APPLICANT MEASUREMENTS – RANGE OF MOTION (ROM) AVAILABLE FOR SEATING

HIP ROM R: _____ **L:** _____	**KNEE ROM R:** _____ **L:** _____	**ANKLE ROM R:** _____ **L:** _____

WHEELCHAIR FEATURES – SELECT ALL THAT APPLY

DRIVE CONTROL	BACK CANE ANGLE	LEG RESTS	FOOTPLATES	ARM PAD	ARM REST
☐ **Single Drive joystick** ☐ **Multiple Drive controller*** ☐ **Specialty Drive Controls***	**Available range: 86° to 122° seat to back angle in 4 degree increments** **Set at:** _____	☐ **60 degree** ☐ **STD** ☐ **HD** ☐ **70 degree** ☐ **STD** ☐ **HD** ☐ **90 degree center Mount*** *(with manual elevation)* **Set leg rest length to: (inches):** _____	☐ **Flip up, composite** ☐ **Flip up, angle adjustable*** ☐ **Heel Loops** ☐ **Yes** ☐ **No** ☐ **One-Piece footboard** *(only with center mount)*	☐ **Standard arm pad** ☐ **Waterfall arm pad*** ☐ **Full Length** ☐ **Right** ☐ **Left** ☐ **Desk Length** ☐ **Right** ☐ **Left**	☐ **Dual Post Height Adjustable** ☐ **Reclining*** **Flip Up Height Adjustable** **(Only option available with approval for power recline)**
JOYSTICK MOUNT ☐ **Right hand** ☐ **Left Hand** ☐ **Swing-Away (OTP)**					

JUSTIFICATION FOR ANY ITEMS MARKED "J" ON THE ORDER FORM OR MARKED WITH AN ASTERISK* ABOVE:

PLEASE PROVIDE BILLING INSTRUCTIONS TO SMD REGARDING ANY ITEMS MARKED "OTP" ON THE ORDER FORM OR ABOVE:

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **The applicant is aware that SMD Wheelchair Services will only provide ONE mobility device per client.**

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

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 any time.
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:** _____