SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax 9204) 975-3240 Toll Free 1-800-836-5551

(SMD-001) Category 1 MANUAL WHEELCHAIR APPLICATION

Write Legibly and provide ALL requested information.

Applicant will need the wheelchair ☐ Less than 6 months ☐ More than 6 months

Check the box that is most applicable to the applicant

☐ Occasional user. Can walk more than 80 feet / 25 meters without aid but need a wheelchair when fatigued or for long outings.

☐ New application ☐ Exchange application

Reason(s) for exchange _____

☐ Palliative. When renting is not possible, a standard category 1a or 1b transport chair is available for persons considered at the **end stage of a terminal illness**. Clients in hospice are not eligible. If palliative, indicate if:

☐ URGENT (for palliative applicants who require the wheelchair full time)

☐ REGULAR (for palliative applicants who require the wheelchair part time)

APPLICANT

First name (Please print)	Last name	
Date of Birth (mm/dd/yyyy)	Gender ☐ male ☐ female	PHIN #
Home Address	City	Postal Code
Home phone	Cell phone	E-mail

Residence is a PCH or institution ☐ yes ☐ no 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)

BILLING INFORMATION

Applicant is eligible to receive funding for prescribed wheelchair from any of these other funding sources

☐ Medical Services funding provide NIHB # _____

☐ Veterans Affairs funding provide DVA # _____

☐ Employment and Income Assistance provide EIA # _____

Full Name of EIA Case Coordinator _____Office location _____

Telephone _____ Fax _____

NEXT OF KIN (must be residing in Manitoba)

First name (print)	Last name	Relationship to applicant
Home address	City	Postal Code
Home phone	Cell phone	E-mail

PHYSICIAN (complete this section only if applicant is funded by NIHB)

First Name (please print)	Last Name	Signature
Registration #	Phone	Fax
Address	City	Postal Code

PRESCRIBER (Registered nurse or physician may prescribe category 1 wheelchair for MBH and EIA applicants)

First name (Please print)	Last name	Position
Address	City	Postal Code
e-mail	Phone	Fax

DIAGNOSIS AND OTHER PRESENTING CONDITIONS RELATED TO THE NEED FOR THE WHEELCHAIR

WHEELCHAIR SPECIFICATIONS

Current weight _____ lbs Height _____feet/inches

Category	☐ Category 1a (for applicant weighing less than 250 lbs. or 300 lbs) ☐ Category 1b (for applicant weighing more than 300 lbs. up to 450 lbs.)
Applicant's actual measurement	Measure hip width (straight line) or widest part of the body _____ Measure distance (straight line) from back or buttocks to the back of the knee _____ Measure distance (straight line) from the bottom of the heel to the back of the knee _____ Measure distance (straight line) from sitting surface to axilla _____
Seat Width	☐ 16" ☐ 18" ☐ 20" for cat 1a (250 lb. wt. capacity for 16" or 18" and 300 lb. wt. capacity for 20" wide) ☐ 22" ☐ 24" for cat 1b (450 lbs weight capacity for 22" and 24" wide)
Seat Depth	☐ 16" (available only on 16", 18" , and 20" wide chairs) ☐ 18" (available only on 22" and 24" wide chairs)
Seat Height	☐ 17.75" ☐19.75" (available only on 16", 18", and 20" wide wheelchairs) ☐ 21" (available on 22" and 24" wide wheelchairs)
Back Height	☐ 16"
Armrests	☐ Full length fixed height removable ☐ Desk Length fixed height removable
Leg rests	☐ 70 degree hangers with composite footplates ☐ Elevating leg rests with composite footplates
Tires	☐ Solid Rubber
Wheel lock extensions	☐ No ☐ Yes ☐ Right only ☐ Left only ☐ Both

NOTE Anti-tippers are not available on cat 1wheelchairs.

Prescribed wheelchair will fit in client's home environment. ☐ yes ☐ no

Information provided in this application is based on client's current measurements. ☐ yes

Prescriber's Signature_____ Date _____

EQUIPMENT LOAN AGREEMENT AND PRIVACY STATEMENT

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

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

1. I am only entitled to use the equipment while I am a full time resident of Manitoba. If I move outside Manitoba, I will return the equipment before I leave 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 place 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 the 6 months before I enter the personal care home.
11. The Manitoba Wheelchair Program may re-assess my need for the equipment at any time.
12. 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. I realize 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's signature	Witness signature	Witness name (print)	Date

If client cannot write, a LEGAL REPRESENTATIVE may sign above on behalf of the client.
If you are signing as a legal representative, complete information below.

_____	_____	_____	_____
Printed name and signature	Relationship to applicant	Address	Date