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

(SMD-002) Category 2 MANUAL WHEELCHAIR APPLICATION

Write legibly and provide ALL requested information

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

☐ **NEW APPLICATION** ☐ **EXCHANGE APPLICATION**

Reason (s) for exchange ____

Without reasonable justification exchanges will not be considered.

☐ **Regular** ☐ **Urgent***** *** applicant is a full time user and has no other means of mobility and/or will be discharged from hospital in 3-6 days.

Applicant is in hospital ☐ yes ☐ no Discharge date ______________________

Client can pick up wheelchair from SMD ☐ yes ☐ no If **YES**, person to contact and phone # ______________________

NOTE Prescribing therapist must inform SMD if there is a change in discharge location (i.e. PCH, chronic care)

APPLICANT

First Name (print)		Last Name
Date of Birth (mm/dd/yyyy)	Gender ☐ male ☐ female	PHIN #
Home Address	City	Postal Code
Mailing address if different from above		
E-mail	Home Phone	Cell Phone

Residence is a PCH or institution ☐ yes ☐ no Is paneled / will be paneled to PCH ☐ yes ☐ no

BILLING INFORMATION

Applicant is eligible to receive funding for prescribed wheelchair from any of these 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 (print)	Last Name	Signature
Registration #	Phone	Fax
Address	City	Postal Code

PRESCRIBER (must be an occupational therapist or physiotherapist registered to practice in Manitoba)

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

ELIGIBILITY

Primary Diagnosis and onset

Other presenting conditions related to the need for the prescribed wheelchair

Transfers ☐ independently ☐ with assist ☐ requires mechanical lift

Ambulates ☐ independently ☐ with standby supervision ☐ with assist ☐ unable to walk

Requires walking aid ☐ yes ☐ no ______________________

Distance applicant is able to walk __________ feet

Method of propulsion ☐ arms only ☐ feet only ☐ both arms and feet ☐ does not propel

Check the box that appropriately describes the applicant

☐ **Part time user** *(3-5 hours a day),*
Attendant assist. *Does not propel the wheelchair, is pushed all the time.*

☐ **Part time user** *(3-5 hours a day),*
Partially independent propeller. *Propels independently within home environment and immediate outdoors but needs assist some of the time.*

☐ **Part time user** *(3-5 hours a day),*
Independent propeller. *Propels independently within home environment and immediate outdoors.*

☐ **Full time user** *(minimum of 6 hours a day)*
Attendant assist . *Client does not propel the wheelchair, is pushed all the time.*

☐ **Full time user** *(minimum of 6 hours a day),*
Partially independent propeller. *Propels independently within home environment and immediate outdoors but needs assist some of the time.*

☐ **Full time user** *(minimum of 6 hours a day)*
Independent propeller. *Propels independently within home environment and immediate outdoors. No assist required.*

☐ **Full time user** *(minimum of 6 hours a day)*
Partially independent propeller. *Propels independently within home environment and immediate outdoors but needs assist some of the time.*
If full time user, partially independent propeller and requesting for cat 2C, provide justification. ____

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☐ **Part time user** *(3-5 hours a day),*
Independent propeller. *Propels independently within home environment and immediate outdoors.*
If part time user, independent propeller and requesting for cat 2C, provide justification. ____

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WHEELCHAIR SPECIFICATIONS

CURRENT weight ________ lbs. height ________feet/inches Is weight likely to change? ☐ yes ☐ no
If yes, explain____

Requesting ☐ 2A ☐ 2B ☐ 2C **NOTE** If requesting 2B or 2C, complete a Rubix spec sheet and submit with this application.

Applicant's Actual measurements must be provided	Wheelchair Dimensions
Measure hip width (straight line) or widest part of the body ________	**Seat width** ________ **inches**
Measure distance (straight line) from back or buttocks to the back of the knee ________	**Seat depth** ________ **inches**
Measure distance (straight line) from the bottom of the heel to the back of the knee ________	**Seat height** ________ **inches**
Measure distance (straight line) from sitting surface to axilla _______	**Back Height** _________ **inches**

Arm rests ☐ Full length height adjustable ☐ Desk length height adjustable

Legrests Standard 70 degrees ☐ right ☐ left Elevating leg rests (ELR) ☐ right ☐ left
Justification for ELR ____

Wheel lock extensions ☐ yes ☐ no If **yes,** ☐ right only ☐ left only ☐ both

Anti tippers ☐ yes ☐ no **NOTE** Supplied only if bilateral amputee or chair has horizontal axle adjustment. Otherwise, option to purchase.

If 2B or 2C, set axle at ☐ 1" forward of back canes ☐ level with back canes.

If 2B or 2C, provide justification for features that have (2) beside it in the spec sheet. ____

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Prescribed wheelchair will fit in applicant's home environment. ☐ Yes ☐ No
If no, describe plan to access home ____

Information provided in this application is based on applicant's assessment and current measurements. ☐ yes
Applicant was informed that only solid rubber tires are available on category 2A. ☐ yes
Client was informed that SMD will not service pneumatic tires and spoke wheels. ☐ yes

Delivery instructions if different from the client's address____

Prescriber's Signature ____________________________________Date completed__________________________

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