SOCIETY FOR MANITOBANS WITH DISABILITIES – WHEELCHAIR SERVICES
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
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(SMD-004) Category 4 MANUAL WHEELCHAIR APPLICATION

Write Legibly and provide all requested information

☐ **NEW APPLICATION** ☐ **EXCHANGE APPLICATION** Without reasonable justification exchanges will not be considered

Reason (s) for exchange: ____

____

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		
Home Phone	Cell Phone	e-mail

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

☐ Medical Services funding provide NIHB # ____________________

☐ Veterans Affairs funding provide DVA # ____________________

☐ Employment and Income Assistance provide EIA # ____________________

EIA Case Coordinator ______________________________Office location ____________________

Telephone ______________________________ Fax ____________________

NEXT OF KIN (Must be residing in Manitoba)

First Name (Please print)	Last Name	Relationship to client
Home Address	City	Postal Code
Home phone	Cell phone	e-mail

PHYSICIAN (must be completed 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 (Please print)	Last Name	Position
Address	City	Postal Code
e-mail	Phone	Fax

ELIGIBILITY

Primary Diagnosis and date of onset

Other presenting medical conditions related to the need for the prescribed wheelchair

Functional mobility status related to the need for the prescribed wheelchair

Transfers ☐ independently ☐ with assist ☐ requires mechanical lift Describe ____________________

Ambulates ☐ Independently ☐ Walks with standby supervision ☐ Walks with assist ☐ Unable to walk

Distance __________meters / feet Requires walking aid ☐ yes ☐ no ______________

Applicant requires the use of the wheelchair __________ hours a day

☐ Daily ☐ 4-5 times a week ☐ 2-3 times a week ☐ other __________

Indoor Propulsion: ☐ Attendant Assist
☐ Partially independent (requires assist some of the time)
☐ Fully Independent (does not require assist at all)

Method of independent propulsion ☐ Using arms only
☐ Using feet only
☐ Using both

Applicant requires the use of the prescribed wheelchair to perform the following activities in his/her place of residence.

____ ____

____ ____

____ ____

____ ____

Outdoor Propulsion ☐ Attendant Assist
☐ Partially independent (requires assist some of the time)
☐ Fully Independent (does not require assist at all

Applicant often goes out of his/her place of residence ☐ alone ☐ with spouse ☐ other _______________
☐ Daily ☐ 4-5 times a week ☐ 2-3 times a week ☐ other ___________

Requires use of the prescribed wheelchair to perform the following activities beyond his/her place of residence. State frequency.

____ ____

____ ____

____ ____

____ ____

Outside of his/her place of residence, applicant will propel the prescribed wheelchair.

Inside a building	☐ independently	☐ partially independent	☐ attendant assist	frequency _________________
On paved street	☐ independently	☐ partially independent	☐ attendant assist	frequency _________________
Sidewalk	☐ independently	☐ partially independent	☐ attendant assist	frequency _________________
Gravel road	☐ independently	☐ partially independent	☐ attendant assist	frequency _________________
Rough terrain	☐ independently	☐ partially independent	☐ attendant assist	frequency _________________

Applicant ☐ is employed ☐ attends school ☐ volunteers # hours a per week _______________

Transportation ☐ Own vehicle ☐ Taxi ☐ Bus transit ☐ Handi Transit ☐ Other__________________

If using own vehicle, applicant will be the ☐ driver ☐ passenger Who will load the wheelchair into the vehicle? ___________________

Applicant has a privately owned power mobility ☐ yes ☐ no

Environment Applicant lives ☐ alone ☐ with spouse ☐ other ________________

NOTE A home visit is required to ensure that home is accessible and that there are no restrictions to wheelchair use in applicant's home**.** Considerations should also be made to work, school and leisure environments.

A home visit was done. ☐ yes ☐ no Who did the home visit? _________________________________

If unable to do a home visit, what was done to determine if requested wheelchair can access and fit into applicant's home?

____

Place of residence is a ☐ house ☐ apartment ☐ group home ☐ assisted living ☐ PCH
Entrance has a ☐ Lift ☐ Ramp with railing (according to code) ☐ Level entrance ☐ Stairs (# of steps ________)

If entrance is not level and has no ramp, how will client independently and safely enter/exit place of residence? ___________________

____

If entrance has a ramp, can client independently propel the wheelchair up and down the ramp ☐ yes ☐ no

If no, how will client enter/exit place of residence? ____

Prescribed wheelchair can access all areas of the home that the client requires to access ☐ yes ☐ no

If no, what is done to ensure access to these areas? ____

____

Work environment is accessible for the prescribed wheelchair ☐ yes ☐ no ☐ NA
School environment is accessible for the prescribed wheelchair ☐ yes ☐ no ☐ NA

WHEELCHAIR SPECIFICATIONS

Requires rigid Frame ☐ yes ☐ no Justification ____

____

Requires horizontal axle adjustment ☐ yes ☐ no Justification ____

Requires vertical axle adjustment ☐ yes ☐ no Justification ____

NOTE Because there are four (4) choices for category 4 folding frame and three (3) choices for category 4 rigid frame please indicate what model is being requested and provide required justification to support the request, including client's functional performance in the requested wheelchair and features found in the chair that meet the client's identified needs from your assessment. Fill out the spec sheet (download from the SMD website) for the selected wheelchair and fax to SMD with this application.

☐ Quickie LXI ☐ Quickie Xi ☐ Quickie 2 ☐ Quickie GPSA ☐ Quickie GPV ☐ Q7 ☐ M6

Justification for choice of wheelchair____

Justification for features that have (2) beside it in the spec sheet

Features	Justification- include data from mat assessment

WHEELCHAIR SPECIFICATIONS

CURRENT weight ______ lbs height ______ feet/in Is weight likely to change? ☐ yes ☐ no If yes,explain__________________________

Must provide applicant's actual measurements	Wheelchair dimensions (without seating system)
hip width or widest part of the body _______ inches	**Wheelchair Seat width _____ inches**
thigh length _______ inches	**Wheelchair Seat depth _____ inches**
leg length ______ inches	**FRONT Seat height ______ inches REAR seat height _____ inches** **Leg rest length _____ inches**
Back height ________	**Wheelchair Back Height _________ inches**

Arm rests ☐ Full length ☐ Desk length

Legrests Standard 70 degrees ☐ right ☐ left Other than 70 degrees, specify __________________ ☐ right ☐ left

Footplates Composite ☐ right ☐ left Other than composite , specify ______________________ ☐ right ☐ left

Set wheel axle at ___________________________________

Delivery instructions if different from applicant's address

Applicant was informed that he/she will not be eligible for a power chair for two years following receipt of a category 4 wheelchair. ☐ yes

Applicant has been informed that current chair they have on loan from the program will be returned. ☐ yes ☐ n/a

Applicant has been informed that SMD will not service pneumatic tires and spoke wheels. ☐ yes

Information provided in this application is based on applicant'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