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-005) POWER WHEELCHAIR APPLICATION

Write Legibly and provide all requested information .

☐ **New Application** ☐ **Repairs to own power wheelchair. Must be pre-inspected by SMD technician.**

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 / institution ☐ yes ☐ no 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 # _____

Full name of EIA Case Coordinator _____Office location _____

Telephone _____ Fax _____

NEXT OF KIN (Must be residing in Manitoba)

First Name (print)	Last Name	
Home Address	City	Postal Code
Relationship to applicant	Home phone	Cell phone

PHYSICIAN (Must be completed only if applicant is funded by NIHB)

☐ It is my opinion that provision of a power wheelchair is required to improve this applicant's functional status.

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

PRESCIRBER (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

MEDICAL STATUS

Primary Diagnosis **and** date of onset

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

CURRENT MOBILITY

1. Transfers ☐ independently ☐ with assist ☐ requires mechanical lift
2. If applicant is unable to walk, check here ☐ then proceed to # 5
3. Indoor ambulation

   Ambulates ☐ independently ☐ with standby assist ☐ with supportive assist
   Approximate distance of independent **indoor** ambulation _____ **feet**
   Devices used ☐ none ☐ Cane ☐ Crutches ☐ Walker ☐ Other _____

Additional Comments _____

_____

4. Outdoor ambulation

Ambulates ☐ independently ☐ with standby assist ☐ with supportive assist
Approximate distance of independent **outdoor** ambulation _____ **feet**
Devices used ☐ none ☐ Cane ☐ Crutches ☐ Walker ☐ Other _____

Additional Comments_____

_____

To what extent are limitations in ambulation affected by the following? Mark appropriate box.

	N/A	Mildly	Moderately	Severely
Decreased upper extremity strength	☐	☐	☐	☐
Decreased lower extremity strength	☐	☐	☐	☐
Decreased upper extremity ROM	☐	☐	☐	☐
Decreased lower extremity ROM	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Poor standing balance	☐	☐	☐	☐
Limited endurance	☐	☐	☐	☐
Altered tone	☐	☐	☐	☐
Poor coordination	☐	☐	☐	☐
Altered sensation	☐	☐	☐	☐
Pain (specify) _____	☐	☐	☐	☐

Additional Comments _____

_____

If applicant does not use a manual wheelchair, check here ☐ and proceed to # 8 below

5. Make and Model _____ Date obtained _____From _____
6. Approximate distance of independent **indoor** propulsion _____ ☐ feet ☐ meters

Additional Comments _____

_____

7. Approximate distance of independent **outdoor** propulsion _____ ☐ feet ☐ meters

Additional Comments _____

_____

8. To what extent are limitations in manual wheelchair propulsion **OR** potential manual wheelchair propulsion (if applicant does not currently use one) affected by the following? Mark appropriate box.

	N/A	Mildly	Moderately	Severely
Decreased upper extremity strength	☐	☐	☐	☐
Decreased lower extremity strength	☐	☐	☐	☐
Decreased upper extremity ROM	☐	☐	☐	☐
Decreased lower extremity ROM	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Poor standing balance	☐	☐	☐	☐
Limited endurance	☐	☐	☐	☐
Altered tone	☐	☐	☐	☐
Poor coordination	☐	☐	☐	☐
Altered sensation	☐	☐	☐	☐
Pain (specify) _____	☐	☐	☐	☐

Additional Comments _____

_____

9. Applicant has a ☐ scooter ☐ power wheelchair

Owned by ☐ self ☐ _____

Make and model_____ Date obtained _____

Uses ☐ indoors ☐ outdoors ☐ indoors and outdoors Hours / day _____ # times a week _____

☐ Does not use. Why not? _____

Comment on suitability/unsuitability of current power mobility _____

_____

LIFESTYLE / USAGE PROFILE

1. It is anticipated that the applicant will use the power wheelchair
   ☐ mostly in the community ☐ mostly inside the home ☐ inside the home AND community
   If power chair is for use in the community only, state reason why applicant cannot use a scooter._____
   _____

2. It is anticipated that the applicant will use the power wheelchair
   ☐ as the primary method of mobility (DAILY) ☐ 4-5 times a week ☐ 2-3 times a week ☐ once a week
   Additional comments _____
   _____

3. Mark if applicant is independent, assisted, or dependent, **AND** describe how the use of a power wheelchair will facilitate applicant's participation in these activities

   ☐ Grooming ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Dressing ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Bathing ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Toileting ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Meals ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Meal Prep ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Cleaning ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Laundry ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Shopping ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Dishwashing ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Computer ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Banking ☐ **I** ☐ **A** ☐ **D** _____

   Describe applicant's child care responsibilities: ☐ N/A
   How would use of a power wheelchair facilitate participation in child care activities? _____
   _____

4. Is the applicant currently employed? ☐ yes ☐ no ☐ on leave
   ☐ Full time ☐ Part time Hours per week _____ Position held _____
   If on leave, will the applicant return to work? ☐ yes ☐ no If yes, when? _____
   Power wheelchair will be used at worksite? ☐ yes ☐ no
   If power chair will not be used , why not? _____

5. Is the applicant currently enrolled in an education program? ☐ yes ☐ no
   Institution applicant is attending _____ ☐ Full time ☐ Part time Hours per week _____
   Power wheelchair will be used at school? ☐ yes ☐ no
   If power chair will not be used, why not? _____

6. Is the applicant currently involved in volunteer activity? ☐ yes ☐ no
   Organization(s) and hours per week _____
   Power wheelchair will be used at volunteer site? ☐ yes ☐ no
   If NO, why not? _____

7. Does applicant participate in leisure / recreational activities? ☐ yes ☐ no

Activity	Frequency	Location	power chair will be used
_____	_____	_____	☐ yes ☐ no
_____	_____	_____	☐ yes ☐ no
_____	_____	_____	☐ yes ☐ no
_____	_____	_____	☐ yes ☐ no

   If power chair will not be used, why not? _____

8. Does the applicant have regularly scheduled medical appointments ☐ yes ☐ no

Medical appointment (s)	Frequency	power chair will be used
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no

If power chair will not be used, why not? _____

9. Approximate total number of hours per day the applicant will use the power wheelchair to participate in the above activities (# 1-9)? _____

SUPPORT SYSTEM

1. The applicant lives ☐ alone ☐ with spouse / partner ☐ with parents ☐ with children ☐ with attendant
2. What current mobility assistance is required by the applicant **in his/her place of residence**? _____

_____

Who provides this mobility assistance? _____

Does client receive Home Care support? ☐ yes ☐ no If yes, how often? _____

Assistance provided_____

What would be the effect on these supports if applicant used a power wheelchair? _____

_____

3. What current mobility assistance is required by the applicant **beyond his/her place of residence**? _____

_____

Who provides this mobility assistance? _____

What would be effect on these supports if applicant used a power wheelchair? _____

_____

4. If applicant does not have a support system to assist with mobility, describe the impact that a power wheelchair would have on the client's level of independence. _____

PHYSICAL ENVIRONMENT

1. Indicate setting of applicant's place of residence ☐ rural ☐ urban
2. Describe applicant's place of residence ☐ Private home ☐ owned ☐ rented
   ☐ Apartment / condo ☐ owned ☐ rented
   ☐ Assisted Living / Independent living
   ☐ Group Home
   ☐ Personal Care Home / Chronic Care Facility
3. Home accessibility

   Entrance has a ☐ level entrance ☐ Ramp with safe railing (according to code) ☐ Lift ☐ Stairs (# of steps_____)

Access measurements		power chair can access	plans to ensure accessibility
Entrance	_____	☐ yes ☐ no	_____
Bathroom	_____	☐ yes ☐ no	_____
Bedroom	_____	☐ yes ☐ no	_____
Living room	_____	☐ yes ☐ no	_____
Kitchen	_____	☐ yes ☐ no	_____
Tight corners	_____	☐ yes ☐ no	_____
Elevator	_____	☐ yes ☐ no	_____

Who did a home visit to verify this information? _____

4. Is a move anticipated? ☐ yes ☐ no Date of move _____ Is the new home accessible? _____
5. Is there a safe (locked), heated, dry, well ventilated location where to store the power wheelchair? ☐ yes ☐ no Where? _____
6. Is the applicant's school/work environment compatible with the use of a power wheelchair? ☐ yes ☐ no ☐ N/A
   If NO, does school/employer agree to make the required modifications to facilitate the use of a power wheelchair? ☐ yes ☐ no
7. Are the environments for medical appointments compatible with the use of a power wheelchair? ☐ yes ☐ no
8. Transportation plans ☐ Accessible Transit ☐ Handi Transit ☐ Own accessible van ☐ Car ☐ Other _____

   If using own van, applicant will be the ☐ driver ☐ passenger

   When not traveling on any of the above types of vehicle, client will be driving the power wheelchair on

   ☐ Paved streets how often _____ ☐ _____ how often _____

   ☐ Paved sidewalks how often _____

   ☐ Gravel roads how often _____

   ☐ Rough terrain how often _____

POWER WHEELCHAIR DRIVING ASSESSMENT

1. Driving assessment was completed using ☐ RWD ☐ MWD ☐ Both

Scoring guide 1 – Completely safe and independent
2 – Completes task hesitantly, requires several tries, or bumps into objects or people
3 – Unable to complete task
4 – Not assessed. Provide reason.

	Score	Additional comments
Has adequate vision to be safe	_____	_____
Has adequate hearing skills to be safe	_____	_____
Operate the joystick	_____	_____
Operate on/off switch	_____	_____
Operate speed control	_____	_____
Drive forward on a straight line	_____	_____
Drive backward straight	_____	_____
Turn right safely	_____	_____
Turn left safely	_____	_____
Tight U-turn	_____	_____
Wide U-turn	_____	_____
Stop on command	_____	_____
Stop within 4 inches w/o hitting object	_____	_____
Enter and exit a room	_____	_____
Approach a table	_____	_____
Adjust speed as needed	_____	_____
Recognize and avoid hazard	_____	_____
Manoeuver chair in small space	_____	_____
Open automatic door	_____	_____
Enter/exit through automatic door	_____	_____
Drive up/down a ramp	_____	_____
Drive on rough ground	_____	_____
Drive on sidewalk	_____	_____
Manage curbs	_____	_____
Cross a street safely	_____	_____
Follow traffic rules	_____	_____
Can follow instructions	_____	_____
Can problem solve	_____	_____
Demonstrates Safety awareness	_____	_____
Aware of cause and effect	_____	_____
Focuses on task	_____	_____
Drive in unstructured environment	_____	_____

2. Will the applicant require supervision when driving the power wheelchair? ☐ yes ☐ no

If yes, what support /supervision is required? _____

PRESCRIBING THERAPIST'S GENERAL IMPRESSIONS

It is my opinion that provision of a power wheelchair is the most appropriate means of improving this applicant's functional status. ☐ yes ☐ no

Client was informed that the program will not provide a back up manual wheelchair. ☐ **yes**
Client was informed that the manual wheelchair previously issued to the client will be returned to SMD. ☐ **yes** ☐ **n/a**
Client was informed that power wheelchair will require appropriate seating. ☐ **yes**
Client has been informed that SMD will not service pneumatic tires. ☐ **yes**

Therapist's signature_____ Date _____

WHEELCHAIR SPECIFICATIONS

NOTE There is one (1) choice for RWD power chair and two (2) choices for MWD power chair. Please indicate what drive wheel you are requesting and provide required justification to support the request. Make a selection for the model of MWD and provide justification. The program will not retrofit TDX SC with power positioning device. Fill out the spec sheet (download from the SMD website) for the selected wheelchair and fax to SMD with this application. Contact the SMD Occupational Therapist if applicant's weight exceeds the weight capacity of power chairs available in the program.

☐ RWD ☐ MWD Justification _____

☐ TDX SC ☐ TDX SP Justification _____

Provide justification for requested features that have (2) beside it in the spec sheet

Feature	Justification – include data from your assessment

CURRENT weight _____ lbs. height _____ feet / in. Is weight likely to change? ☐ yes ☐ no If yes, explain_____

Must provide client's actual measurements	**Wheelchair specifications (without seating system)**
Client's hip width or widest part body _____ inches.	**Wheelchair seat width** _____ **inches**
Client's thigh length _____ inches	**Wheelchair seat depth** _____ **inches**
Client's leg length _____ inches	**Wheelchair seat height** _____ **inches** **Leg rest length** _____ **inches**
Client's Back height_____ inches	**Wheelchair back height** _____ **inches**

Applicant's hip flexion for seating _____ **Back / seat angle** _____ **Seat angle** _____

Armrests Full length adjustable ☐ right ☐ left Desk length adjustable ☐ right ☐ left

Front rigging

Center Pivot hanger

60˚ swing away (**RWD**) ☐ right ☐ left
70˚ swing away (**RWD & MWD**) ☐ right ☐ left
90˚ swing away (RWD) ☐ right ☐ left
Elevating leg rests (**RWD**) ☐ right ☐ left

Center Pivot footplates

☐ Composite
☐ Aluminum
☐ Angle adjustable

Center Mount hanger

☐ Center mount (**MWD**)
(maximum length is 12" and 15")

Center Mount footplates

☐ Small Footplates ☐ Large Footplates
☐ Medium Footplates ☐ One-piece footboard

Joystick ☐ right ☐ left

1. Applicant needs to mount other devices (e.g. ventilator) to the power wheelchair? ☐ yes ☐ no
Describe device _____

2. Who will charge the batteries daily? _____

NOTE MWP provides sealed gel batteries that require daily charging to ensure functional use and this is the responsibility of the consumer.

3. Is delivery to applicant's home address? ☐ yes ☐ no Deliver to _____
NOTE Wheelchair Services will deliver to one address only.

Client has been informed that power wheelchair requires seating. ☐ yes
Client has been informed that SMD will not service pneumatic tires ☐ yes

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