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-006) POWER WHEELCHAIR EXCHANGE APPLICATION

Write Legibly and provide all requested information.

(Without reasonable justification exchanges will not be considered)

Reason(s) for power wheelchair exchange request _____

_____

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

Residing in a PCH / 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 # _____

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 (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

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

MEDICAL STATUS

Primary Diagnosis **and** date of onset

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

Has there been a change in medical status since client received current power wheelchair? ☐ yes ☐ no

If yes, please describe _____

Describe how these changes have affected applicant's use of the current power wheelchair. _____

_____

CURRENT MOBILITY

1. Transfers ☐ independently ☐ with assist ☐ requires mechanical lift
2. If applicant is unable to walk, check here ☐ then proceed to Lifestyle / Usage profile section
3. Approximate distance of **indoor** ambulation _____ **feet**
   Ambulates ☐ independently ☐ with standby assist ☐ with supportive assist
   Devices used ☐ none ☐ Cane ☐ Crutches ☐ Walker ☐ Other _____
4. Approximate distance of **outdoor** ambulation _____ **feet**
   Ambulates ☐ independently ☐ with standby assist ☐ with supportive assist
   Devices used ☐ none ☐ Cane ☐ Crutches ☐ Walker ☐ Other _____

LIFESTYLE / USAGE PROFILE

1. Applicant drives the power chair independently ☐ yes ☐ no
2. Applicant uses the power wheelchair
   ☐ mostly in the community ☐ mostly inside the home ☐ inside the home AND community
3. Applicant uses the power wheelchair
   ☐ as the primary method of mobility (DAILY) ☐ 4-5 times a week ☐ 2-3 times a week ☐ once a week
4. Mark if client is independent, assisted, or dependent **AND** describe how the use of a power wheelchair facilitates 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** _____
   ☐ Banking ☐ **I** ☐ **A** ☐ **D** _____
   ☐ Computer ☐ **I** ☐ **A** ☐ **D** _____

5. Describe applicant's child care responsibilities: ☐ N/A _____
   _____
   Is power chair used in child care responsibilities? ☐ yes ☐ no If not used, why not? _____
   _____
6. Is the applicant currently employed? ☐ yes ☐ no ☐ Full time ☐ Part time Hours per week _____
   Is power chair used at worksite? ☐ yes ☐ no If not used, why not? _____
   _____
7. Is the applicant currently enrolled in an school? ☐ yes ☐ no ☐ Full time ☐ Part time Hours per week _____
   Is power chair used at school? ☐ yes ☐ no If not used at school, why not? _____
   _____
8. Is the applicant currently involved in volunteer activity? ☐ yes ☐ no Location and hours per week _____
   Is power chair used at volunteer site? ☐ yes ☐ no If not used , why not? _____
   _____
9. Does the applicant have regularly scheduled medical appointments ☐ yes ☐ no

Medical appointment (s)	Frequency	power chair is used	If no, why not?
_____	_____	☐ yes ☐ no	_____
_____	_____	☐ yes ☐ no	_____
_____	_____	☐ yes ☐ no	_____

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

Activity	Frequency	power chair is used	If no, why not?
_____	_____	☐ yes ☐ no	_____
_____	_____	☐ yes ☐ no	_____
_____	_____	☐ yes ☐ no	_____
_____	_____	☐ yes ☐ no	_____

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

SUPPORT SYSTEM

Describe the effect that the use of power wheelchair has had on the applicant's support system / caregiver requirements. _____

_____

PHYSICAL ENVIRONMENT

1. Indicate setting of applicant's place of residence ☐ rural ☐ urban

Place of residence
- ☐ Private home ☐ owned ☐ rented
- ☐ Apartment / condo ☐ owned ☐ rented
- ☐ Assisted Living / Independent living
- ☐ Group Home
- ☐ Personal Care Home / Chronic Care Facility

2. Home accessibility **NOTE** the new power wheelchair may have different overall dimensions from the current wheelchair.

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

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	_____

Current power wheelchair can access all areas of the home that client needs to access. ☐ yes ☐ no

If no, what areas of the home can it not access? _____

What was done to ensure access to those areas? _____

Who did a home visit to verify this information? _____

3. Is the current power chair stored in a safe (locked), heated, dry, well ventilated location? ☐ yes ☐ no Where? _____

4. Transportation

☐ Accessible Transit ☐ Handi Transit ☐ Own van ☐ car ☐ _____

If using own van, applicant is the ☐ driver ☐ passenger

When not traveling on any of the above types of vehicle, client drives the power wheelchair on

- ☐ Paved streets how often _____
- ☐ Paved sidewalks how often _____
- ☐ Gravel roads how often _____
- ☐ Rough terrain how often _____
- ☐ _____ 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	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	_____	_____
Pays attention to environment	_____	_____
Focuses on task	_____	_____
Drive in unstructured environment	_____	_____

2. Does applicant require supervision when driving the power chair? ☐ yes ☐ no

   If yes, what supports /supervision is required? _____

SCRIPTOR'S GENERAL IMPRESSIONS

Comment on suitability of continued provision of power wheelchair to the applicant.

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

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

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

Center Mount footplates

☐ Small Footplates
☐ Medium Footplates
☐ Large 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