Manitoba Possible.

Manitoba Wheelchair Program (MWP)
1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7
Phone (204) 975-3250 Fax (204) 975-3240 Toll Free 1-800-836-5551

MANUAL WHEELCHAIR APPLICATION
CATEGORY 2A

Note: Illegible or incomplete application forms will be returned to the prescriber

☐ **NEW APPLICATION** Client requires a wheelchair for permanent medical needs/longer than 6 months.	☐ **EXCHANGE APPLICATION** **REASON FOR EXCHANGE:** ____________________

☐ **REGULAR:** Applicant requires the wheelchair part-time/has an interim wheelchair to use
☐ **URGENT:** Applicant has no other means of mobility and is at increased safety-risks without wheelchair

CURRENTLY IN HOSPITAL? ☐ **YES** ☐ **NO** **Discharge Date:** ____________ **Discharge Location:** ____________

Delivery Instructions (If different than home address): ____________________

CLIENT DEMOGRAPHICS (PLEASE PRINT)

FIRST NAME	**LAST NAME**	
DATE OF BIRTH (MM/DD/YYYY)	**GENDER**	**PHIN**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

RESIDENCE LIVES IN PCH OR INSTITUTION: ☐ **YES** ☐ **NO**	**APPLICANT IS PANELED/ACCEPTED TO PCH:** ☐ **YES** ☐ **NO**

NEXT OF KIN (MUST BE A MANITOBA RESIDENT)

FIRST NAME	**LAST NAME**	**RELATIONSHIP TO APPLICANT**
HOME ADDRESS	**CITY**	**POSTAL CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**

THIRD PARTY FUNDING INFORMATION (COMPLETE AREAS THAT APPLY)

☐ **EMPLOYMENT & INCOME ASSISTANCE** (Not applicable for clients who live in the community) Case Number: ____________________	☐ **NON-INSURED HEALTH BENEFITS** ☐ **NIHB Loan Agreement attached** 10-digit number: ____________________

☐ The prescriber has verified the applicant is not eligible WCB, MPIC, Victim's Services funding and/or is not a ward of Child & Family Services

PRESCRIBER INFORMATION

☐ **OCCUPATIONAL THERAPIST**	☐ **PHYSIOTHERAPIST**	☐**OTHER, SPECIFY:**
FIRST NAME	**LAST NAME**	**REGISTRATION #**
ADDRESS	**CITY**	**POSTAL CODE**
EMAIL	**PHONE**	**FAX**

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DIAGNOSIS AND/OR PRESENTING CONDITION(S) RELATED TO THE NEED FOR A WHEELCHAIR

PRESCRIPTION

☐ **2A: Breezy Easy Care 4000** *Note: Applicant's weight must not exceed 250lbs.*

ASSESSMENT FINDINGS: USAGE PROFILE & PROPULSION STATUS

☐ **Part Time User (3-6 hours per day)**		☐ **Full Time User (6+ hours per day)**
☐ **Attendant Assist** *(Does not propel, always needs assistance)*	☐ **Partially Independent** *(Requires assist in some environments/outdoors /longer distances/etc.)*	☐ **Independent** *(Propels independently in all environments)*

APPLICANT MEASUREMENTS

CURRENT WEIGHT: __________ lbs./ kg (circle one) **HEIGHT: __________ ft. in./ cm (circle one)**

	Information provided in this application must reflect applicant's current measurements	**Measurement (inches)**
MEASUREMENTS	**Hip Width**: (straight line) or widest part of body in sitting	
	Thigh Length: (straight line) from back of buttocks to back of knee	
	Lower leg length: (straight line) from back of knee to bottom of heel	
	Back height: Sitting surface to axilla	

WHEELCHAIR PARAMETERS

SEAT WIDTH	☐ **16"**	☐ **18"**	☐ **20"**
SEAT DEPTH	☐ **16"** ☐ **18"**	☐ **16"** ☐ **18"**	☐ **18"**
SEAT HEIGHT	☐ **17.75"** ☐ **19.75"**	☐ **17.75"** ☐ **19.75"**	☐ **19.75"**
BACK HEIGHT	☐ **16"** ☐ **18"**	☐**16"** ☐ **18"**	☐ **16"** ☐ **18"**

WHEELCHAIR ACCESSORIES

HEIGHT ADJUSTABLE FLIP BACK ARMREST	**LEG RESTS w/ composite footplates**	**WHEEL LOCK EXTENSIONS**	**ANTI-TIPPERS**
☐ **Full length** ☐ **Desk length**	☐ **70 degrees swing-away**	☐ **No** ☐ **Yes:** ☐ **Right** ☐ **Left**	☐ **No** ☐ **Yes**
SEAT BELT	☐ **Elevating Leg Rests (ELR): Needs Justification:**	**Needs Justification:**	**Needs Justification:**
Please choose one : ☐ **No** ☐ **Yes**			

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **Prescribed wheelchair will fit in applicant's home environment.**
☐ **I have reviewed the Equipment Loan Agreement with the Applicant and/or Representative.**

____ ______________________________
Prescriber's Signature **Date**

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EQUIPMENT LOAN AGREEMENT

The equipment is the property of Winnipeg Regional Health Authority (WRHA) Manitoba Wheelchair Program as operated by Manitoba Possible.

1. I am entitled to use the equipment while I am a full-time resident of Manitoba. If I move outside of Manitoba, I will return the equipment before leaving 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 indoor space 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 at least 6 months before admission to the Personal Care Home.
11. The Manitoba Wheelchair Program may re-assess my eligibility for the equipment at anytime.
12. I will promptly return the equipment to the Manitoba Wheelchair Program if I a) am no longer eligible under the Manitoba Wheelchair Program OR b) no longer need the equipment OR c) fail to observe the terms of this agreement. I recognize 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. Manitoba Possible 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 the Manitoba Wheelchair Program and/or Manitoba Possible to disclose my personal health information contained in my wheelchair application to authorized personnel for the sole purpose of processing my wheelchair request.**

Client Signature: ____ **Date:** _____________

If client cannot write, a **LEGAL REPRESENTATIVE** may sign on behalf of the client below:

Name: _______________________ **Signature:** ______________________ **Relationship to Client:** _____________

Witness Name: __________________________________ **Witness Signature:** ____________________________