Manitoba Possible.

Manitoba Wheelchair Program
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 2C / 2C(HD)

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

☐ NEW APPLICATION	☐ EXCHANGE APPLICATION REASON FOR EXCHANGE: _____

DEMOGRAPHICS (PLEASE PRINT)

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

RESIDENCE IS A PCH OR INSTITUTION: ☐ YES ☐ NO	APPLICANT IS PANELED/WILL BE PANELED TO PCH ☐ YES ☐ NO

CURRENTLY IN HOSPITAL? ☐ YES ☐ NO Discharge Date: _____ Discharge Location: _____

Note: Prescribing therapist must inform MWP if there is a change in discharge location (i.e. PCH, Chronic Care)

Delivery Instructions (If different than home address): _____

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

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	FACILITY NAME
REGISTRATION #	PHONE	FAX
ADDRESS	CITY	POSTAL CODE
SIGNATURE	EMAIL	DATE

MEDICAL DIAGNOSES AND FUNCTIONAL IMPLICATIONS REQUIRING USE OF MANUAL WHEELCHAIR

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ELIGBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY

***REQUIREMENT:** ☐ Applicant will require the chair for long term/ indefinite (i.e. greater than 6 months)

***REQUIREMENT:** ☐ Full Time User (minimum 6 hours per day) **AND** ☐ Independent propeller in all environments

***Justification must be provided below if required criteria do not apply.**

OR ☐ Physical and/or Functional limitations preclude the use of Category 2A **(provide justification below)**

AND ☐ Functional performance will be increased with the use of Category 2C **(provide justification below)**

☐ Ambulation tolerance is limited - up to 25 meters with or without a gait aid, specify: _____ meters/feet with _____ (gait aid)

☐ Requires no more than 2" of horizontal axle adjustability (3" for Pediatric, Zippie GS)

2C (HD) applications only: ☐ Applicant weight precludes application for Category 2A wheelchair

PRESCRIPTION – MWP RESERVES THE RIGHT TO SELECT A CHAIR BASED ON INVENTORY LEVELS

☐ Zippie GS	☐ 2C: Move	☐ 2C (HD): Move HD

☐ **ORDER FORM FOR SELECTED MANUAL WHEELCHAIR ATTACHED**

RATIONALE FOR WHEELCHAIR SELECTION: *(MUST BE COMPLETED)*

APPLICANT MEASUREMENTS – INFORMATION PROVIDED MUST REFLECT CURRENT MEASUREMENTS

CURRENT WEIGHT: _____ lbs/ kg (circle one)	HEIGHT: _____ ft. in./ cm (circle one)	
	Measurement (inches)	**Recommended Wheelchair Dimensions (inches)**
HIP WIDTH: (straight line) or widest part of body in sitting		**SEAT WIDTH:**
THIGH LENGTH: (straight line) back of buttocks to back of knee		**SEAT DEPTH:**
LOWER LEG LENGTH: (straight line) back of knee to bottom of heel		**SEAT TO FLOOR HEIGHT:**
BACK HEIGHT: Sitting surface to axilla		**BACK HEIGHT:**

APPLICANT MEASUREMENTS – RANGE OF MOTION (ROM) AVAILABLE FOR SEATING

HIP ROM R: _____ L: _____	KNEE ROM R: _____ L: _____	ANKLE ROM R: _____ L: _____

WHEELCHAIR FEATURES

ARMRESTS	LEG RESTS	FOOTPLATES	AXLE SETTING	ANTI-TIPPERS	WHEEL LOCK EXTENSIONS	BACK CANES
☐ Full length ☐ Desk length ☐ Flip back ☐ T-style	☐ 70 degree ☐ Elevating*	☐ Standard ☐ Angle adjustable*	☐ 0.75" ☐ 2"	☐ No ☐ Yes	☐ No ☐ Yes ☐ Right ☐ Left	☐ Standard ☐ Angle adjustable*

Justification for any items above marked with an asterisk*

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: _____