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

ULTRA-LIGHTWEIGHT MANUAL WHEELCHAIR APPLICATION

CATEGORY 4

PEDIATRIC AND ADULT

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

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

ELIGIBILITY CRITERIA – THERAPIST CONFIRMS THE FOLLOWING CONDITIONS APPLY

***REQUIREMENT:** ☐ Applicant is a full time user (6+ hours per day for school, recreation, ADL and IADL function).

***REQUIREMENT:** ☐ Applicant is independent with self-propulsion in all environments

***REQUIREMENT:** ☐ Home has an accessible entrance: (circle one) street level entrance ramp platform lift

Verified by: _____

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

☐ Applicant requires an ultra-lightweight manual wheelchair to meet their basic and essential mobility requirements in their home and community.

☐ Has physical or functional limitation(s) which preclude the use of a category 2C (justification provided below) AND functional performance will improve with use of adjustability only available on a Category 4 manual wheelchair.

☐ Applicant's home environment has been assessed by an Occupational Therapist (Date of assessment: _____)

Note: *Category 4 wheelchairs will not be provided for ease of caregiver.*

PRESCRIPTION

FOLDING FRAME	☐ **Zippie GS**	☐ **Helio Kids**	☐ **Helio A6** ☐ **Helio A6 HD** *(up to 350lbs)*	☐ **Quickie M6** *(up to 650lbs)*
BOX FRAME	☐ **Quickie GP/ GPV**		☐ **Quickie GP Swing-Away**	
CANTILEVER FRAME	☐ **Apex**			

☐ **ORDER FORM FOR THE PRESCRIBED WHEELCHAIR ATTACHED TO APPLICATION FORM**

RATIONALE FOR FRAME TYPE (FOLDING, BOX OR CANTILEVER):

RATIONALE FOR WHEELCHAIR MODEL SELECTION:

DESCRIBE WHY A CATEGORY 2C/ 2C(HD) IS NOT ADEQUATE and/or FURTHER JUSTIFICATION (IF APPLICABLE):

FUNCTIONAL STATUS

TRANSFER STATUS	☐ **Independent**	☐ **With Assistance**	☐ **Mechanical Lift**
INDOOR PROPULSION STATUS	☐ **Independent**	☐ **Partially Independent**	☐ **Attendant Assist**
OUTDOOR PROPULSION STATUS	☐ **Independent**	☐ **Partially Independent**	☐ **Attendant Assist**
AMBULATION STATUS	☐ **Independent** *(Describe gait aid used)* **Approximate Distance:**	☐ **With assistance** *(Describe)* **Approximate Distance:**	☐ **Non-ambulatory*** **(Proceed to next section)**

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

CURRENT WHEELCHAIR / MOBILITY DEVICE – COMPLETE IF APPLICABLE

MAKE AND MODEL: _____	YEAR OBTAINED:	FROM:

DESCRIBE FACTORS THAT LIMIT OR NEGATIVELY IMPACT APPLICANT'S ABILITY TO USE THEIR CURRENT MOBILITY DEVICE:

SUPPORT SYSTEM

APPLICANT LIVES: ☐ **ALONE** ☐ **WITH SPOUSE/PARTNER/ROOMMATE(S)** ☐ **WITH CHILDREN** ☐ **WITH ATTENDANT** ☐ **WITH PARENTS**

DOES THE APPLICANT RECEIVE HOME CARE SUPPORT? ☐ **NO** ☐ **YES**
IF YES, DESCRIBE:

DESCRIBE THE LEVEL OF MOBILITY ASSISTANCE CURRENTLY PROVIDED BY SUPPORTS LISTED ABOVE AND THE IMPACT A CATEGORY 4 MANUAL WHEELCHAIR MAY HAVE ON THESE SUPPORTS

FUNCTIONAL CONSIDERATIONS

DESCRIBE THE SELF-CARE TASKS CURRENTLY COMPLETED AT A WHEELCHAIR LEVEL AND HOW A CATEGORY 4 MANUAL WHEELCHAIR WILL ENHANCE APPLICANT'S INDEPENDENCE WITH THESE TASKS:

DESCRIBE ANY COMMUNITY OR HOME MANAGEMENT TASKS THE APPLICANT MUST COMPLETE AND DESCRIBE HOW A CATEGORY 4 MANUAL WHEELCHAIR WILL ENHANCE THEIR INDEPENENCE WITH THESE TASKS: *(Include usage information related to employment, school, recreational or leisure activities)*

HOME ASSESSMENT

☐ **Prescriber has determined applicant's school/work environment(s) are accessible with use of a manual wheelchair**

DESCRIBE APPLICANT'S CURRENT RESIDENCE: *Select all that apply*

☐ URBAN ☐ RURAL	☐ DETACHED HOUSE ☐ APARTMENT/ CONDO	☐ OWNED ☐ RENTAL	☐ INDEPENDENT ☐ GROUP HOME ☐ WITH FAMILY	☐ ASSISTED LIVING ☐ SUPPORTIVE HOUSING	☐ PCH/ CHRONIC CARE FACILITY

ACCESSIBILITY CONSIDERATIONS

A HOME VISIT/ ACCESSIBILITY ASSESSMENT WAS COMPLETED **WITH** THE PRESCRIBED WHEELCHAIR IN THE APPLICANT'S HOME ☐ YES ☐ NO

IF A TRIAL WITH THE PRESCRIBED WHEELCHAIR WAS NOT COMPLETED IN THE APPLICANT'S HOME, WHAT HAS BEEN DONE TO ENSURE ACCESSIBILITY OF THE MANUAL WHEELCHAIR INSIDE THE HOME?

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

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) from back of buttocks to back of knee		**SEAT DEPTH:**
LOWER LEG LENGTH: (straight line) from back of knee to bottom of heel		**SEAT TO FLOOR HEIGHT:** _____ **(FRONT)** _____ **(REAR)**
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 – SELECT ALL THAT APPLY

ANTI TIPPERS	LEG RESTS	FOOTPLATES	BACK CANES	ARMRESTS	ARM PADS
☐ Yes ☐ No	☐ 60 degree ☐ 70 degree ☐ 80 degree ☐ 90 degree ☐ Elevating *	☐ Composite ☐ Angle adjustable* ☐ Flip Back, angle adjustable * ☐ Tubular ☐ with cover ☐ open loop ☐ Heel Loops ☐ Yes ☐ No	☐ Standard, fixed height Set height to: _____" ☐ Angle adjustable ☐ straight cane ☐ 8 degree bend Set back cane angle to: (inches) _____	☐ T-style* ☐ Padded Swing-Away ☐ Omit*	☐ Full Length ☐ Desk Length ☐ N/A
BRAKE EXTENSIONS ☐ No ☐ Yes ☐ Right ☐ Left					
CENTER OF GRAVITY **Axle Position:** *(inches)* _____" **Forward of back canes**	**Set leg rest length to: (inches)** _____				

JUSTIFICATION FOR ANY ITEMS MARKED "J" ON THE ORDER FORM OR MARKED WITH AN ' * ' ASTERISK ABOVE:

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **I have reviewed the Equipment Loan Agreement with the Applicant and/or Representative**

Prescriber's Signature _____ **Date** _____

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

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: _____