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

POWER WHEELCHAIR (PWC) APPLICATION
CATEGORY 5 – PEDIATRIC AND ADULT

☐ **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: **Note**: may be provided with a recycled or substituted equipment if it meets basic and essential mobility needs.

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**

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

☐ The client resides in a facility (e.g., PCH). Must provide EIA# if applicable:

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**

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 FUNCTIONAL IMPLICATIONS REQUIRING USE OF PWC

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: ☐ The applicant intends to use the PWC inside their home and in the community.
Note: *Manitoba Wheelchair Program (MWP) does not provide PWCs for community-use only*

REQUIREMENT: Home has an accessible entrance, please check one:
☐ Street level entrance ☐ Ramp ☐ Platform lift ☐ Other: _____

REQUIREMENT: Home Environment Assessment Completed/Verified by: _____
On this date: _____.

REQUIREMENT: ☐ An in-chair power wheelchair driving assessment was completed – see page 3.

Applicant's Eligibility:

- ☐ Cannot propel a manual wheelchair independently to meet his/her basic and essential mobility requirements in their home.
- ☐ Has not received a Category 3 or Category 4 wheelchair within the past 2 years.
- ☐ Able to store the PWC in an area that is: indoors, locked, heated and well-ventilated.
  Note*: Sheds/ detached garage are not considered a suitable storage area.*
- ☐ Able to/has a caregiver who can ensure daily battery charging and basic chair maintenance can be completed.
- ☐ Is aware of the **recommended/proper transportation securement protocol** when travelling in a vehicle.
- ☐ Has been informed that MWP only provides ONE basic mobility device and any wheelchair previously on loan must be returned to 1857 Notre Dame (if applicable). *MWP will not supply a back-up manual chair.*
- ☐ Has been informed that the PWC will require seating components that are *NOT* available through MWP.

Recommended Equipment

MID WHEEL DRIVE	REAR WHEEL DRIVE	BARIATRIC MIDWHEEL DRIVE
☐ Pediatric: Zippie Xperience2 (300lbs)	☐ Pediatric: Zippie Xplore2 (300lbs)	
☐ Adult: Quickie Xperience2 (300lbs)	☐ Adult: Quickie Xplore2 (300lbs)	☐ Adult: Quickie Xcel2 (550lbs)
☐ Adult: Quickie Xperience2HD (400lbs)	☐ Adult: Quickie Xplore2 HD (400lbs)	

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

RATIONALE FOR DRIVE WHEEL SELECTION:

PWC DRIVING TRIAL (If unable to complete, please contact MWP Clinical Specialist to discuss):

IN-CHAIR DRIVING ASSESSMENT COMPLETED BY:

_____ **on** _____
Therapist Name **Date**

TYPE & NAME OF PWC USED FOR ASSESSMENT:

ASSESSMENT LOCATION:

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POWER WHEELCHAIR DRIVING SKILLS ASSESSMENT

PRESCRIBER'S RATING GUIDE	DEFINITIONS:
E	**EXCELLENT:** CONSISTENTLY DEMONSTRATES SAFE OPERATION, INDEPENDENT WITH TASK, NO CONCERNS NOTED
S	**SATISFACTORY & SAFE**: REQUIRES SEVERAL ATTEMPTS/PRACTICES TO COMPLETE TASK, VERBAL CUEING NEEDED; DISPLAYED NERVOUS TENDENCIES/HESITATION
U	**UNSATISFACTORY/ UNSAFE:** UNABLE TO COMPLETE TASK; DEMONSTRATED UNSAFE OPERATION
N/E	NOT EVALUATED - PROVIDE REASON
N/A	NOT APPLICABLE – PROVIDE REASON

DRIVING SKILLS	OVERALL RATING FOR EACH	PLEASE COMMENT ON EACH SECTION (PRESCRIBER'S IMPRESSIONS):
SECTION 1: ABILITY TO OPERATE JOYSTICK/CONTROLS: ▪ OPERATE ON/OFF SWITCH ▪ OPERATE SPEED CONTROL ▪ OPERATE MODE SWITCH ▪ RELEASE JOYSTICK/CONTROLS ▪ OPERATE POWER ACTUATORS		
SECTION 2: COMPLETION OF BASIC SKILLS: ▪ STOP & GO WITH CUEING VS. SELF INITIATED ▪ RIGHT TURNS ▪ LEFT TURNS ▪ 360°TURN (TOWARDS RIGHT & LEFT) WITHIN 5' CIRCLE ▪ REVERSE 5' DISTANCE ▪ NAVIGATE THROUGH WIDE HALLWAYS (3-4' WIDE)		
SECTION 3: COMPLETION OF ADVANCED SKILLS: ▪ ENTER/EXIT ELEVATOR ▪ APPROACH A TABLE ▪ PARALLEL PARK - # OF ATTEMPTS ▪ NAVIGATE THROUGH NARROW DOORWAY/HALLS ▪ DRIVE IN BUSY/UNSTRUCTURED AREAS ▪ IN/OUT OF BATHROOM ▪ UP/DOWN RAMP ▪ SAFELY USE AUTOMATIC DOORS AND MANUAL DOORS		
SECTION 4: COMPLETION OF OUTDOOR SKILLS: ▪ DRIVE ON PAVED SIDEWALK ▪ DRIVE ON UNEVEN TERRAIN/ ROUGH SURFACE (I.E.: GRASS, SNOW, GRAVEL) ▪ CROSS STREET SAFELY, OBEYING TRAFFIC LIGHTS ▪ MANAGE 2" CURB		
SECTION 5: COGNITIVE SKILLS ▪ CAN FOLLOW INSTRUCTIONS ▪ CAN PROBLEM SOLVE ISSUES ▪ RECOGNIZE AND AVOID OBSTACLES ▪ DEMONSTRATES AWARENESS OF THEIR SURROUNDINGS ▪ UNDERSTANDS RULES OF THE ROAD		

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CURRENT FUNCTIONAL STATUS

TRANSFER STATUS:	☐ **Independent**	☐ **With Assistance**	☐ **Mechanical Lift**
AMBULATION STATUS:	☐ **Independent** **(Describe gait aid used)** **Approximate Distance:**	☐ **With assistance** **(Describe)** **Approximate Distance:**	☐ **Non-ambulatory**
UPPER EXTREMITY FUNCTION – Describe *(i.e., dominant hand, grasp, etc.):*		**TRUNK BALANCE – Describe** *(i.e., leaning tendency, forward reach, etc.):*	

CURRENT WHEELCHAIR / MOBILITY DEVICE

Make and Model:	**Year Obtained:**	**From:**

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

DESCRIBE WHY A MANUAL WHEELCHAIR IS NOT SUITABLE FOR THIS APPLICANT:

SUPPORT SYSTEM

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

DOES THE APPLICANT RECEIVE HOME CARE SUPPORT?

☐ **NO**

☐ **YES** – Describe Assistance/Tasks:

LIST OTHER MOBILITY-RELATED ASSISTANCE PROVIDED BY APPLICANT'S SUPPORT SYSTEM (if applicable):

DESCRIBE THE IMPACT A PWC WOULD HAVE ON THESE SUPPORTS:

DESCRIBE THE TRAINING/EDUCATION PLAN FOR SUPPORT PERSONS TO LEARN ABOUT THE PWC:

POTENTIAL FUNCTIONAL GAINS WITH A PWC

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

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

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ENVIRONMENTAL AND ACCESSIBILITY CONSIDERATIONS

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

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

A HOME VISIT/ ACCESSIBILITY ASSESSMENT WAS COMPLETED **WITH** PWC IN THE APPLICANT'S HOME: ☐ NO - PROVIDE REASON: ☐ YES

	AREA OF HOME	MEASUREMENTS	ACCESS ISSUE IDENTIFIED? (circle one)	PLANS TO ENSURE ACCESSIBILITY
HOME ASSESSMENT	FRONT ENTRANCE		Yes / No	
	BATHROOM		Yes / No	
	BEDROOM		Yes / No	
	LIVING ROOM		Yes / No	
	KITCHEN		Yes / No	
	HALLWAY		Yes / No	
	ELEVATOR		Yes / No	
	RAMP WIDTH (IF APPLICABLE)		Yes / No	

TRANSPORTATION

PLANS FOR IN-VEHICLE TRANSPORTATION: *Select all that apply.*

☐ OWN VEHICLE ☐ WINNIPEG TRANSIT PLUS

☐ OTHER PWC-ACCESSIBLE TRANSPORT SPECIFY): _____

☐ **PRESCRIBER HAS DISCUSSED THE PROPER USE OF TRANSPORT TIE-DOWNS FOR PWC AND IN-VEHICLE TRANSPORTATION WITH CLIENT AND/OR FAMILY.**

WORK/SCHOOL/OTHER

☐ PRESCRIBER HAS DETERMINED THAT THE ENVIRONMENT IS ACCESSIBLE WITH USE OF PWC.

☐ PRESCRIBER HAS IDENTIFIED THE FOLLOWING CONCERNS WITH THE ENVIRONMENT:

APPLICANT'S 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:**
BACK HEIGHT: Sitting surface to axilla		**BACK HEIGHT:**

FUNCTIONAL SEATING AND POSITIONING

Applicant's Postures for PWC SEATING:

- **Hip Flexion – Extension ROM:** **L** _____ **R** _____
- **Hip Abduction-Adduction ROM:** **L** _____ **R** _____
- **Pelvic Position:** ☐ **Posterior Tilt** ☐ **Anterior Tilt** ☐ **Neutral**
- **Pelvic Obliquity:** ☐ **Left High** ☐ **Right High** ☐ **Neutral**
- **Knee flexion – Extension ROM:** **L** _____ **R** _____
- **Ankle Dorsi-Plantar Flexion ROM:** **L** _____ **R** _____

Prescriber has evaluated applicant's seating system based on best practice standards of ~every 5 years or with change in function. Current System:

☐ **Cushion type/name:**

☐ **Backrest type/name:**

☐ **Other/Positioning Components:**

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WHEELCHAIR FEATURES – Provide Justification* for Non-Standard Options Refer to PWC Electronic Handout for Actuator Selection Options				
DRIVE CONTROL	☐ R-Net LED (No Screen) – **Standard Option** 	☐ R-Net w/color screen*  **Justification:**	☐ OMNI2* *(Required for specialty controls)*  **Justification –** attach a separate report to describe the trials completed with specialty controls.	
TILT OPERATION *(If Applicable)*	☐ Through Joystick - **Standard**	☐ Through Switch*, select one:  Toggle  Dual Push Buttons **Justification:**	☐ Dual activation*: use both joystick and switch *(Available for specialty controls only)* **Justification** - attach a separate report to describe the trials completed with specialty controls.	
LEG RESTS Requested leg rest length: _____"	☐ Swing-Away Footrests - Standard ☐ 60 degrees ☐ 70 degrees 	☐ Swing-Away Footrests – **HD*** ☐ 60 degrees ☐ 70 degrees  ☐ **Justification** - only if requested on non-HD PWC	☐ Fixed Center Mounts – 90 degrees 	☐ Power Swing Away Power Centre-Mount* **Justification** - must accompany Power Dynamic Positioning Application Form for power tilt; strongly recommend trial with the actuators.

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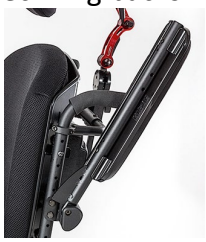
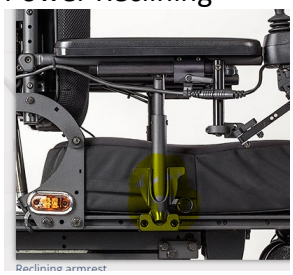
FOOT-PLATES	☐ Flip up, composite, **Standard**	☐ Flip up, angle adjustable* **Justification:**	☐ Flip up, One-Piece footboard *(only with center mount)* ☐ Angle-Adjustable, Split Footplates *(only with center mount)*
ARM-RESTS	☐ Dual Post, Height-Adjustable – Standard 	☐ Cantilever, Flip Up, For non-reclining backs*  **Justification:**	☐ Power Reclining*  **Justification:** Must accompany Power Dynamic Positioning Application Form *and* Trial with the power recline actuators should be completed.
ARMPADS	☐ Waterfall: **Full Length** – 14” ☐ Left ☐ Right	☐ Waterfall: **Desk Length** – 10” ☐ Left ☐ Right	☐ Standard arm pad* *(Typically flat pads to fit lap trays)*

Other Comments/Additional Justification Notes:

PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:

☐ **The applicant meets all Eligibility Criteria as outlined on page 2.**
☐ **I have reviewed the Equipment Loan Agreement with the Applicant and/or Representative.**

Prescriber’s Signature: _____ **Date:** _____

Prescriber’s Printed Name:

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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 for using 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: _____