



Temporary Chair Application – For Paneled Clients Note: Illegible or incomplete application forms will be returned to the prescriber

APPLICANT WILL REQUIRE WHEELCHAIR FOR:	 ☐ Temporary use, up to 3 months ☐ Extended, maximum 6 months: must be accompanied by Justification Letter 				
PRIORITY LEVEL OF APPLICATION	,		,		
CURRENTLY IN HOSPITAL?	☐ YES, Discharge	Date:			
Date Accepted to Panel: Accepting Facility/PCH (If known):					
Community Discharge Location:	•				
(If different than home address) Note: Clients are expected to return the chairs	to MWP when they are	in PCH and have had th	e chair for <i>less</i> than 6 mos		
DEMOGRAPHICS (PLEASE PRINT)					
FIRST NAME LAST NAME					
DATE OF BIRTH	GENDER		PHIN		
(MM/DD/YYYY)	GENDER				
HOME ADDRESS	CITY		POSTAL CODE		
HOME PHONE	CELL PHONE		EMAIL		
Home Care Case Coordinator (REQUIRED)					
FIRST NAME	LAST NAME		Contact Info:		
OFFICE ADDRESS	CITY /POSTAL CODE				
FUNDING INFORMATION					
☐ Home Care Case #			☐ The prescriber has verified the		
- Home date dase #			applicant is not eligible WCB,		
□ EIA # (if Applicable)			MPIC, Victim's Services funding		
☐ Temporary Loan Agreement Attached			and/or is not a ward of Child & Family Services .		
PRESCRIBER INFORMATION					
□ OCCUPATIONAL THERAPIST	□ PHYSIOTHERA	PIST	□ OTHER, SPECIFY:		
FIRST NAME	LAST NAME		REGISTRATION #		
ADDRESS	CITY		POSTAL CODE		
EMAIL	PHONE		FAX		
LIVIALE	PHONE		I AA		

1 of 3 Client Initials: MWP: Temporary Chair Dec 2022



MEDICAL DIAGNOSES AND FUNCTIONAL IMPLICATIONS RELATED TO NEED FOR WHEELCHAIR								
ASSESSMENT FINDINGS: USAGE PROFILE & PROPULSION STATUS								
☐ Part Time User (3-6 hours per day)		☐ Full Time User (6+ hours po			rs per day)			
□ Attendant Assist (Does not propel/dependent; pushed at all times)	☐ Partially Independer (Requires assist in some e outdoors or for longer dis		environments/ (Propels i		□ Indepe (Propels i environm	ndependently in all		
APPLICANT MEASUREME	NTS							
CURRENT WEIGHT:	lbs./ kg (circle one)		HEIGHT:			ft. in./ cm (circle one)		
	INFORMATION PROVIDED IN THIS APPLICATION MUST REFLECT APPLICANT CURRENT MEASUREMENTS			ICANT'S	Measurement (inches)			
	Hip Width: (straight line) or widest part of body in sitting							
MEASUREMENTS	gth: (straight line) from bac	k of buttocks to back of		ck of				
	Lower leg length: (straight line) from back of knee to bottom of heel							
	Back height: Sitting surface to axilla							
BASIC WHEELCHAIR PAR	AMETERS	3						
SEAT WIDTH		□ 16 ″		□ 18″		□ 20 ″		
SEAT DEPTH	□ 16″	□ 18″	□ 16″	□ 18″		□ 18 ″		
SEAT HEIGHT	□ 17.75″	□ 19.75″	□ 17.75″	□ 19.7	5″	□ 19.75″		
BACK HEIGHT	□ 16″	□ 18″	□16″	□ 18″		□16" □18"		
WHEELCHAIR ACCESSOR	IES							
HEIGHT ADJUSTABLE FLIP BACK ARMREST	w/ co	LEG RESTS mposite footplates		EEL LO TENSIO		ANTI-TIPPERS		
☐ Full length	□ 70 degre	ees	□No			□No		
□ Desk length	□ Elevatin Justificat	_	□ Yes □ Right	□ Let	ft	□Yes		
PRESCRIBER CONFIRMS AND ACKNOWLEDGES THE FOLLOWING CONDITIONS:								
 □ Prescribed wheelchair will fit in applicant's home environment □ Discussed with client and home care case coordinator of "temporary" status of wheelchair. 								
Prescriber's Signature Date Date								

2 of 3 Client Initials: _____ MWP: Temporary Chair Dec 2022



TEMPORARY STATUS - LOAN AGREEMENT

<u>This equipment is the property of Winnipeg Regional Health Authority (WRHA) Manitoba Wheelchair Program as operated by Manitoba Possible .</u>

- 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.
- 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.
- 6. I am responsible to use the equipment with reasonable care, keep it clean and regularly maintained.
- 7. If the equipment is lost or stolen, I will contact Manitoba Possible immediately and provide a Police Report if required.
- 8. I will not remove the permanent identification sticker attached to the equipment.
- 9. I will make the equipment available for servicing as necessary.
- 10. The Manitoba Wheelchair Program will have no responsibility for equipment repairs outside of Manitoba.
- 11. Upon acceptance and transfer to a personal care home (PCH), I will return my wheelchair to the Manitoba Wheelchair Program, 1857 Notre Dame Avenue, Winnipeg, Manitoba R3E 3E7.

The Personal Health Information on this application is treated in compliance with "The Personal information Protection and Electronic Act." To serve you better we may need to share your 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 rental equipment agreement. I am legally bound by the terms and accept the equipment on these terms.							
			nal health information contained i rpose of processing my wheelcha					
Clie	nt's Signature	Witness Signature	Witness Name (print)	Date				

3 of 3 Client Initials: _____ MWP: Temporary Chair Dec 2022