

ALBERTA AIDS TO DAILY LIVING (AADL) PROGRAM

ADULT POWER CHAIR APPLICATION

Have you completed/attached?

- Section 1 – Initial Screening
- Signed Client Declaration
- Section 2 – Client Information
- Section 3 – Authorizer Information
- Client Impact Statement
- Manufacturer's Specification Sheet
- 1251 Authorization Form No. _____
- Delivery instructions provided

This application requires that your residence be power wheelchair accessible. You are welcome to contact the Residential Access Modification Program (RAMP) at 780-427-5760 (local Edmonton) or toll free at 310-0000 then dial 780-427-5760 to discuss your needs and your eligibility for a grant of up to \$5000 towards making you home wheelchair accessible.



PLEASE WRITE CLEARLY IN BLACK PEN OR TYPE

Revised October 1, 2007

ALBERTA AIDS TO DAILY LIVING ADULT POWER CHAIR APPLICATION

AUTHORIZER/CLIENT INSTRUCTIONS

Adult Power Mobility Committee meetings are held 10-12 times a year. Any application arriving in AADL will automatically be placed on the agenda for the next available committee meeting.

Limited funds are available for adult power wheelchair purchases. Applications are scored based on the applicant's physical disability, ability to operate a power chair, residential accessibility, lifestyle needs, work needs, educational needs, and personal needs.

AADL BENEFITS AND LIMITATIONS

- AADL does not purchase scooters. AADL buys only those chairs included on the current Approved Products List.
- AADL does not purchase all options listed on the power wheelchair specification sheet. Some of those expenses are passed to the client.
- AADL does not replace lost, stolen, or damaged equipment. Clients should consider the purchase of insurance for AADL owned power wheelchairs.
- If AADL purchases and owns the power wheelchair, AADL will help with repairs, and with the cost of one set of batteries each year if needed.
- Current AADL cost-sharing rules apply to power chairs.

COMMITTEE DECISIONS

Decisions are based on the client's degree of disability, ability to safely operate a power chair, home accessibility, activities, lifestyle, educational and work needs.

Authorizers will be notified by fax (clients by mail) of the committee's decision after the meeting. **Do not phone AADL for decision information.**

Clients receive one of three possible responses:

- Yes, client will receive a power chair this month.
- Yes, the committee agrees with client's need and eligibility, but there is insufficient funding within the Program for an immediate purchase. The application will be held for 3 months to try to secure funding.
- No, the client did not qualify for AADL funding for a chair.

Occasionally committee members feel that the applicant may be eligible, but feel that the Authorizer has failed to provide enough information. In this case, a "No" letter will be sent, but with an added invitation to reapply and submit extra information.

SECTION 1 – INITIAL SCREENING

CLIENT INFORMATION			
Client Name (Last) (First)		Date of Birth Year Month Day	Personal Health Number
Mailing Address		City Town Village	Postal Code
Delivery Address			Client Phone Number Area Code ()
CLIENT'S ALTERNATE CONTACT PERSON			
Contact Name (Last) (First)		Contact Phone Number Area Code ()	
Mailing Address		City Town Village	Postal Code
AUTHORIZER INFORMATION			
Authorizer Name (Last) (First)		Phone Number Area Code ()	Fax Number Area Code ()
Authorizer Signature:			Date:

1. AADL Eligibility:

- Resident of Alberta? YES NO
- Covered by Alberta Health Care Insurance Plan? YES NO

2. Regarding your need for Power Wheelchair – Do you:

- Need power to move around your home? YES NO
- Need power to attend work, school, recreation, and personal business? YES NO
- Live in wheelchair accessible housing? YES NO
- Have ability to care for a power chair, keep batteries charged, etc.? YES NO
- You have a heated, indoor, well-ventilated place to charge batteries? YES NO

If you answered “**NO**” to screening questions 1 & 2, you are not eligible for an AADL power chair. You should discuss alternatives with your Authorizer.

If you answered “**YES**” to screening questions 1 & 2, you may complete the application form by writing or printing legibly with black pen, typing, or filling in an electronic copy on your computer and printing it off. This form must be photocopied for the committee members. AADL needs the original, not a faxed copy, mailed to:

Alberta Aids to Daily Living Program
Seniors and Community Supports
10th Floor, Milner Building
10040 104 Street
Edmonton, Alberta T5J 0Z2

CLIENT DECLARATION:

I HEREBY MAKE APPLICATION TO THE ALBERTA AIDS TO DAILY LIVING PROGRAM FOR A POWER WHEELCHAIR AND AUTHORIZE RELEASE OF INFORMATION AS REQUIRED IN RESPECT TO THIS APPLICATION.

I AM AWARE THAT IF AADL LOANS ME A POWER WHEELCHAIR THAT IT REMAINS THE PROPERTY OF THE GOVERNMENT, AND I WILL RETURN IT IF:

- IT IS NO LONGER NEEDED
- IT HAS BEEN REPLACED
- I AM NO LONGER AN ALBERTA RESIDENT

I AM AWARE THAT THE POWER WHEELCHAIR MAY BE RECYCLED OR NEW.

Name: _____

Signature: _____

- Applicant
- Applicant's Spouse
- Applicant's Parent
- Applicant's Guardian
- Other, specify

SECTION 2 – CLIENT INFORMATION

1. General Medical Information

Diagnosis: _____

Date of Onset: _____ Height: _____ Weight: _____

How has your mobility been affected? _____

How has your condition changed in the last two years? _____

Do you anticipate further changes in the future? _____

2. Current Mobility Equipment

Primary:

Power Chair

Manual Chair

Scooter

Make	Serial No.	Year Received

Secondary:

Power Chair

Manual Chair

Scooter

Make	Serial No.	Year Received

Walker Canes Crutches Braces Prosthesis

If you are requesting a power chair because of problems with current power chair, describe problems:

AADL is not currently helping with repairs (add repair history). History attached? YES NO

AADL repairs chair (AADL will prepare history of chair). Repair estimate attached? YES NO

If you are using a power chair that AADL did not buy, please indicate:

Who paid for it? _____ When? _____

3. How will you transport the power chair?

Have adapted van with lift? NO YES

Will get my van adapted? NO YES, when? _____

By other private vehicle? NO YES, describe: _____

Public transportation? NO YES, describe: _____

Other, describe: _____

Do you travel by air? NO YES

If you live in a small town and public transportation is not available, will you be able to access the town without public transportation? NO YES

4. Do you drive a vehicle? NO YES, what vehicle? _____

5. Do you need to mount other devices to a power chair?

Communication? NO YES, describe: _____
Environmental? NO YES, describe: _____
Respiratory? NO YES, describe: _____

6. Do you need training to be able to use a power chair safely?

NO YES, describe who will train you: _____

7. Where do you live?

Private Home: Owned Rented Group Home
 Apartment/Condo: Owned Rented Long Term Care Facility
 Lodge Assisted Living Residence Other _____

How frequently do you leave your home? Daily 1 or 2 times a week Many times a week
 Several times a month Rarely/Never

Is your community environment wheelchair accessible? NO YES Describe where you go:

YOUR AUTHORIZER MAY ASSIST YOU WITH THE REST OF THIS SECTION:

HOME ACCESSIBILITY

Currently using a power chair and home is fully wheelchair accessible.

Do not fill in the rest of this question. Authorizer Signature _____

OR

Request for first AADL power chair. This section MUST be completed:

Entrance is ground level, no ramp needed YES NO

Entrance has a lift or ramp YES NO

Lift/ramp has safe railing YES NO

Lift /ramp provides level entrance YES NO

Doorway widths: Main entrance _____ Bathroom _____ Bedroom _____
Kitchen _____ Living Room _____ Other _____

Power chair manoeuvred in the following rooms in your residence?

Bedroom Bathroom Kitchen Living Room Hallways Other _____

Do any of these features cause difficulties or safety problems?

Carpets Tight Corners Small Elevators Stairs Bathroom Size Narrow Halls

Open Stairs Other _____

Who did a home visit/trial to verify this information? _____

If residence not accessible, outline immediate plans for making it so: _____

LIFESTYLE

1. Describe client's routine typical day:	How will it change with use of power chair?
a.m.	a.m.
p.m.	p.m.
Evening	Evening
Weekend	Weekend

2. Client Activities

a) **Employment:** NO YES

Current occupation/position held _____

How long in this position? _____ Full time Part Time Hours per day or week _____

Explain how a power chair would increase your employment participation:

b) **Education:** NO YES

Institution client is currently attending: _____

Program: _____

Full time Part Time Hours per day or week: _____

Explain how a power chair would increase your education participation:

c) **Current Volunteer/Community Participation:** NO YES

1) Organization _____

Duties _____

How long has client been doing this? _____

Full time Part Time Hours per day or week _____

2) Organization _____
 Duties _____
 How long has client been doing this? _____
 Full time Part Time Hours per day or week _____

Explain how a power chair would increase your volunteer/community participation:

Supporting letter(s) attached regarding this participation? NO YES

d) Recreational Activities/Socialization/Hobbies: NO YES

This includes activities the client does for fun in their home/lodge/residence or outside of it, with family/friends, in the community, Seniors' Centre, church, etc.

Recreation/Activity	Frequency
Day Program:	

Explain how having a power chair would affect your participation in these activities, if applicable:

e) Household Activities/Home Management: NO YES

Explain how having a power chair would assist you to do the following activities:

Personal care _____
 Home making _____
 Child care _____
 Other family responsibilities _____
 Personal responsibilities _____

3. **Who do you live with?** Alone Spouse/Partner Parents Your Children
 Roommate Attendant Group Home Other Facility _____

What assistance do you need in the home from a caregiver, and how much assistance is available to you? _____

4. **How many hours a day would you use a power wheelchair?** _____

5. **Client Impact Statement –** Attached

The Program would like to hear **from the client** any information they wish to share about how having a power wheelchair will affect their daily life, including how this will affect their caregiver and/or family.

SECTION 3 – AUTHORIZER INFORMATION

AUTHORIZER INFORMATION		ASSESSOR INFORMATION (if different)	
Authorizer Name (Last) (First)		Assessor Name (Last) (First)	
Phone Number Area Code ()	Fax Number Area Code ()	Phone Number Area Code ()	Fax Number Area Code ()
Authorizer Signature		Assessor Signature	

1. Physical Assessment

Diagnosis, stability of physical condition:
Prognosis:
ROM upper extremity:
ROM lower extremity:
Strength upper extremity:
Strength lower extremity:
Stability of weight:
Coordination:
Sitting endurance:
Sitting balance:
Posture:
Hearing:
Cardiac function:
Visual ability:
Respiratory impairment:
Sensation:
Transfer ability: <input type="checkbox"/> Unassisted <input type="checkbox"/> Needs assistance
Cognition, perception, judgment or anything affecting client's ability to safely operate power:
Will the client have any trouble safely using a power chair?

Has ability to propel a manual wheelchair on:

- Smooth surface? NO YES
- Rough outside surface? NO YES
- Carpet surface? NO YES
- Slope - distance/grade? NO YES

How far?	For how long?

2. Authorizer statement

Applicant would benefit from having power chair? YES NO

Applicant could safely use a power chair? YES NO

3. Chairs Trialed

- a) Chairs trialed: _____
- b) Where trialed: Home Work School Recreation Vehicle Public Transport
- c) Dealer who provided trial equipment: _____
- d) Salesperson who helped with chair specs: _____
- e) Preferred dealer: _____

4. Requested Power Chair

- a) Chair requested: _____
- b) Why this model? _____
- c) Special features needed (include control type, tilt, recline): _____
- d) Special seating used during trial? YES NO
- e) Client entered and exited home in power trial? YES NO
- f) Client accessed all parts of home in trial? YES NO
- g) Client's ability to transfer to and from power chair: _____
 independent assistive equipment used required caregiver assistance
- h) Ability to transport power chair trialled: _____
- i) Ability to access work surfaces: _____

POWER WHEELCHAIR SPECIFICATIONS – Attached

Note:

- AADL does not provide all the options (e.g. environmental controls).
- The applicant must be aware that some items may be their financial responsibility.
- This should be addressed on the application.
- Successful applicants will be advised of any items that AADL will not buy.

1. Indicate any extra requirements:

- Seating system (seating clinic aware of this chair choice)
- Power tilt – Form attached? YES NO
- Power tilt/recline – Form attached? YES NO
- Power elevating leg rests – Form attached? YES NO
- Other _____

2. Which special adaptations/accessories are needed? Please describe.

- Environmental control mounting equipment _____
- Communication device mounting equipment _____
- Oxygen holder _____
- Vent tray _____
- Special switches _____
- Other _____

3. Controls

- Joystick position: Left Right Centre
- Other _____

4. Batteries

- Gel Size: _____

AADL ADULT TILT-IN-SPACE REQUEST FORM

1. Complete the form in the spaces provided, grading the client's problem on a 1-5 range (5 being the most severe, and 1 indicating that the factor is not a problem).
2. Add clinical documentation to support the grading score.

Authorizer Name _____ Authorizer No. _____

Client Name _____ PHN _____

Diagnosis _____

Yes No Is client currently using a power tilt system?

Yes No Is client currently using a power tilt/recline system?

Yes No Is client currently using power elevating leg rests?

Describe why current base is no longer appropriate: _____

PHYSICAL FACTORS INDICATING NEED FOR TILT-IN-SPACE

GRADING

Low Need High Need

Inability to maintain upright posture; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Degree of tilt needed to maintain trunk:											
Inability to maintain upright head position; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Degree of tilt needed to maintain head position:											
Inability to weight shift; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reduced sitting tolerance due to fatigue; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Compromised respiratory system; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Pressure relief; describe history of skin problems:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Impaired sensation; describe:	<table style="margin: auto;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	1	2	3	4	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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PHYSICAL FACTORS INDICATING NEED FOR TILT-IN-SPACE

GRADING

Low Need High Need

Improved ability to do ADLs; describe:	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pain relief; describe problem:	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Feeding/swallowing concerns; describe problem:	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Circulatory problems; describe:	1 2 3 4 5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No On trial, did client operate power tilt independently?

Yes No Function and Endurance:
AADL expects that tilt-in-space will allow client to be in mobility base for a minimum of 8 consecutive hours.
Sitting tolerance increased to 8 hours by tilt trial?
If "No", then how long? _____

Yes No Postural Tone:
Extensor pattern prevents sitting, and is reduced/broken by tilt-in-space.

PHYSICAL FACTORS INDICATING NEED FOR POWER TILT/RECLINE

Does client need static or dynamic recline? Static Dynamic

If static recline, describe why the hip angle needs to be opened: _____

If dynamic recline, describe why the hip angle needs to be changed frequently throughout the day:

PHYSICAL FACTORS INDICATING NEED FOR POWER ELEVATING LEG RESTS

Describe the factors that indicate need for power leg rests: _____

Describe the objective outcome of the trial of power elevating leg rests: _____
