

**ALBERTA AIDS TO DAILY LIVING (AADL) PROGRAM**

**PEDIATRIC POWER CHAIR APPLICATION**

**2003**

**If your home requires wheelchair modifications, you may receive up to \$5,000 in grant funding from the Residential Access Modification Program (RAMP). Call 427-5760 (local Edmonton) or toll free at 310-0000 then dial 780-427-5760 to discuss your needs.**



**PLEASE WRITE CLEARLY IN BLACK PEN OR TYPE**



# ALBERTA AIDS TO DAILY LIVING PEDIATRIC POWER CHAIR APPLICATION 2003

## AUTHORIZER/CLIENT INSTRUCTIONS

Application form for determining the client's need and eligibility for a power wheelchair.

Children's applications will be handled in one of two ways:

### a) **First AADL-funded Power Request:**

A child asking for their **first AADL-funded** power chair will be given some latitude regarding their ability to drive, their home accessibility (assuming the chair will be used mainly at school), and their other activities. AADL is willing to give these kids the best chance to become independent and safe power users. The child must demonstrate the potential to drive the power chair after extensive trialling. AADL will provide a lower-end power chair to these children. The family must recognize the need for home accessibility and chair transportation, and sign that they are prepared to take on and begin resolving these issues.

### b) **Request for Replacement AADL-funded Chair:**

A child asking for a **replacement AADL-funded** power chair must be able to safely and independently operate a power chair, and demonstrate frequent (full-time) use of power chair. The family home must be fully wheelchair accessible. Plans to transport the chair must be in place, and the chair must be used at home and in the community as the child's primary mobility. AADL will provide a chair from the APL which is suitable to the indicated need of the client.

## AADL BENEFITS AND LIMITATIONS

Some power wheelchair options will be the client's responsibility (e.g. power tilt-recline).

AADL does not replace lost, stolen, or damaged equipment. Client's family should purchase insurance for AADL-owned power wheelchairs.

AADL will assist with parts, repairs and with the cost of one set of batteries each year if needed.

## AADL DECISIONS

AADL reviews information presented on the application including the applicant's physical disability, ability/potential to operate a power chair, residential accessibility, lifestyle needs, work needs (if applicable), educational needs, recreational needs and personal needs.

Should the AADL reviewer feel there may be relevant information that the authorizer has failed to provide, the authorizer will be requested to submit additional information. Authorizers will be notified of the Program's decision regarding supply of the power chair.

## COMPLETING THE FORM

1. Use black pen or type. Write clearly or print.
2. Complete all necessary parts of this form as follows:

Part 1 – Initial Screening - For **all** pediatric clients

Part 2 – For client who is applying for their **first AADL-funded** power chair

Part 3 – For client who already has an AADL-funded power chair and is applying for a **replacement power chair**

### Have you completed/attached:

- Section 1 – **For all clients - first and replacement** AADL power chair
- Section 2 – only for **first** AADL power chair request
- Section 3 – only for **replacement** AADL power chair
- Manufacturer's Specification Sheet - for **all** applications
- 1251** Authorization Form - for **all** applications:
  - Delivery instructions provided
  - Signed declaration on reverse page of 1251
- Client impact statement - for **all** applications

3. Application form must be mailed. Do not fax it.

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Mail application form to:

Alberta Aids to Daily Living Program  
10<sup>th</sup> Floor, Milner Building  
10040 104 Street  
Edmonton, Alberta T5J 0Z2

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# SECTION 1 - INITIAL SCREENING FOR ALL CLIENTS

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

## 1. Regarding need for Power Wheelchair:

- client needs power to move around your home?       YES       NO
- client needs power to attend/move around school?       YES       NO
- client needs power to attend recreation?       YES       NO
- client living in wheelchair accessible housing?       YES       NO

If applying for first AADL-funded power wheelchair, and if you answered “**NO**” to any part of question 1, the client may still be eligible for an initial AADL power chair.

If this client is applying for a replacement AADL-funded power chair, answers to question 1 must all be answered “YES”. A “NO” answer will make the client ineligible for AADL funding for a replacement power chair.

Parent (or legal Guardian) understands implications of this statement?       YES

Parent or Guardian Name \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

## 2. Regarding care of Power Wheelchair:

- client able to care for a power chair, keep batteries charged, etc?       YES       NO

If not, who will assume this responsibility? \_\_\_\_\_

## CLIENT'S PARENT/LEGAL GUARDIAN SECTION

### DECLARATION:

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

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

- IT IS NO LONGER NEEDED
- IT IS REPLACED
- CHILD IS NO LONGER AN ALBERTA RESIDENT
- CHILD NO LONGER HAS ACTIVE ALBERTA HEALTH CARE INSURANCE

Name \_\_\_\_\_

Signature \_\_\_\_\_

Applicant's Parent

Applicant's Guardian

Other, specify \_\_\_\_\_

# SECTION 2 – FIRST AADL POWER CHAIR

## 1. General Medical Information

Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_

How has child's mobility been affected? \_\_\_\_\_

Do you anticipate further changes in the future? Planned surgeries? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

## 2. Current Primary Mobility Equipment:

Manual chair: Make \_\_\_\_\_ Serial Number \_\_\_\_\_

Walker  Canes  Crutches  Braces  Prosthesis

Power chair/Private owned power chair: Make \_\_\_\_\_ Ser. No. \_\_\_\_\_

Does AADL repair your current power chair?  YES  NO

- If "YES" AADL repairs your chair, AADL will prepare a history of the chair
- If "NO" enclose a maintenance history

If you are using a power chair, please indicate who paid for it \_\_\_\_\_  
and when \_\_\_\_\_.

## 3. How will you transport a power chair?

a) have adapted van with lift  YES  NO

b) will get my adapted van  YES  NO

c) by car  YES  NO

d) no plans at this time  YES  NO

e) public transportation, describe please \_\_\_\_\_

f) other, describe \_\_\_\_\_

g) Does child travel by air?  YES  NO

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

a) Communication  NO  YES, describe \_\_\_\_\_

b) Environmental  NO  YES, describe \_\_\_\_\_

c) Respiratory  NO  YES, describe \_\_\_\_\_

**5. Can child safely propel a power chair at this time?**

YES  NO

a) Does child have ability to follow verbal directions?

YES  NO

b) Does child have ability to indicate correct answers?

YES  NO

c) Does child show motivation to explore his environment?

YES  NO

d) Does child understand cause and effect showing reliable motor response to start and stop the chair?

YES  NO

e) Does child have ability to focus on one activity for 15 minutes?

YES  NO

f) Does child have adequate vision skills to be safe & functional?

YES  NO

g) Does child pay visual attention to environment?

YES  NO

h) Does child have cognitive skills for safety?

YES  NO

i) Can child use kill switch?

YES  NO

j) Does child display speed control in driving?

YES  NO

k) Does child display directional control in driving?

YES  NO

l) Can child drive in a structured environment?

YES  NO

m) Can child drive in an unstructured environment?

YES  NO

n) Does child need training to be able to use a power chair safely?

YES  NO

o) If yes, who will train child? \_\_\_\_\_

Where will this training take place? \_\_\_\_\_

How much training has child had? \_\_\_\_\_

How much training will be required? \_\_\_\_\_

p) Describe current success at driving safely \_\_\_\_\_

Is video available?  YES  NO Enclosed?  YES  NO

## HOME ACCESSIBILITY – WHERE CHILD LIVES

### 1. Where does child live?

- Private home:  Owned  Rented  Group Home  
 Apartment:  Owned  Rented  Long Term Care Facility  
 Other \_\_\_\_\_

How frequently does child leave the home?

- Daily  Several times a month  Rarely/Never

### 2. Child's Home Accessibility

- Entrance has a lift or ramp  Lift/ramp has safe railing  Lift /ramp provides level entrance

Wheelchair successfully trialed in entrances?  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 is not fully accessible, outline plans for making it so: \_\_\_\_\_  
\_\_\_\_\_

**Remember, approval of subsequent request for power chairs depends upon satisfactory accessibility of home.**

### 3. Where else will this chair be used?

#### a) School

- Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance  
 Classrooms accessible  
 Bathroom accessible

#### b) Other, specify \_\_\_\_\_

- Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance

## CHILD'S LIFESTYLE

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

### 2. Describe Child's Activities

a) Rehabilitation/training?  YES  NO

How often? \_\_\_\_\_ Hours per day or week \_\_\_\_\_

Explain how a power chair would increase child's participation: \_\_\_\_\_

\_\_\_\_\_

b) Education:  YES  NO

Institution client is attending \_\_\_\_\_

Program \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

Explain how a power chair would increase child's participation: \_\_\_\_\_

\_\_\_\_\_

c) Volunteer/Community Participation:  YES  NO

1) Organization \_\_\_\_\_

Involvement \_\_\_\_\_

How long has the child been doing this? \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

2) Organization \_\_\_\_\_

Involvement \_\_\_\_\_

How long has the child been doing this? \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

Explain how a power chair would increase child's participation: \_\_\_\_\_

\_\_\_\_\_

Supporting letter(s) attached?  YES  NO

d) Recreational Activities/Socialization/Hobbies:  YES  NO

This includes activities done for fun in your home or outside of it, with your family/friends, in your residence or in your community, etc.

- 1) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 2) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 3) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 4) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_

Explain how having a power chair would affect child's participation in these activities if applicable:

\_\_\_\_\_

**e) Employment (if applicable):**  YES  NO

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 participation: \_\_\_\_\_

\_\_\_\_\_

**f) Household Activities/Home Management (if applicable):**  YES  NO

Duties \_\_\_\_\_

How long have you been doing this? \_\_\_\_\_ Hours per day or week \_\_\_\_\_

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

Personal care \_\_\_\_\_

Home making \_\_\_\_\_

Other family responsibilities \_\_\_\_\_

Personal responsibilities \_\_\_\_\_

**3. Who does child live with?**  Parents  Attendant  Group Home  Institution

What assistance does child need from a caregiver, and how much assistance is available? \_\_\_\_\_

\_\_\_\_\_

**4. How many hours a day would child use a power wheelchair?** \_\_\_\_\_

**5. Client Impact Statement**

The Program would like to hear from the client or the family, any information they wish to share about how a power wheelchair would affect their daily lives.

impact statement attached

## AUTHORIZER/ASSESSOR SECTION

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/anticipated changes:	
ROM upper extremity:	
ROM lower extremity:	
Strength upper extremity:	
Strength lower extremity:	
Weight:	Coordination:
Sitting endurance:	Sitting balance:
Posture:	Respiratory impairment:
Transfer ability:	Perception:
Cardiac function:	Visual ability:
Hearing:	Sensation:
Cognition:	
Ability to propel a manual wheelchair (distance):	
Smooth surface: _____ Rough outside surface: _____	
Carpet surface: _____ Slope - distance/grade: _____	
Will the client have any trouble using a power chair?	

### 2. Assessor statement

Applicant would benefit from having power chair?  YES  NO

Applicant will be able to safely use a power chair?  YES  NO

### 3. Requested Power Chair

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

## POWER WHEELCHAIR SPECIFICATIONS

Attached

### Note:

- AADL does not provide all the options (e.g. power tilt, power recline, environmental controls).
- The applicant must be aware that some items may be their financial responsibility.
- Successful applicants will be advised of any items which will be their financial responsibility.

1. **Why this model was chosen:** \_\_\_\_\_

2. **Is special seating required?**

Seating system (seating clinic aware of this chair choice)

Power tilt/recline

Other \_\_\_\_\_

3. **Will seating system from manual chair be compatible?**

YES  NO

4. **Are special adaptations/accessories needed?**

Environmental control mounting equipment

Communication device mounting equipment

Oxygen holder

Vent tray

Special switches

Other \_\_\_\_\_

5. **Controls**

Joystick position:  Left  Right  Centre

Other \_\_\_\_\_

Any other information you wish to add to this application? \_\_\_\_\_

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# SECTION 3 – REPLACEMENT AADL POWER CHAIR

## 1. General Medical Information

Diagnosis \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Do you anticipate condition changes in the future? \_\_\_\_\_

\_\_\_\_\_

## 2. Current Mobility Equipment:

AADL Power chair: Make \_\_\_\_\_ Serial Number \_\_\_\_\_

Privately owned power chair: \_\_\_\_\_ Year received: \_\_\_\_\_

Does current power chair have: Recline?  NO  YES  manual  power

Tilt?  NO  YES  manual  power

Method of driving current power chair \_\_\_\_\_

Does anyone drive for the client, or assist client to drive?  NO  YES

AADL Manual chair: Make \_\_\_\_\_ Ser. No. \_\_\_\_\_ Year recd: \_\_\_\_\_

Walker  Canes  Crutches  Braces  Prosthesis

Which is child's primary mobility device? \_\_\_\_\_

How many hours per day does child use the power chair? \_\_\_\_\_

Where is this chair at night? \_\_\_\_\_

Where is this chair on the weekends? \_\_\_\_\_

Why does this power chair need to be replaced? \_\_\_\_\_

## 3. How does child transport the power chair?

a) adapted van with lift  NO  YES

b) by other private vehicle  NO  YES, describe \_\_\_\_\_

c) public transportation, describe please \_\_\_\_\_

d) other, describe \_\_\_\_\_

e) Does child travel by air?  NO  YES

## 4. Will other devices be mounted on power chair?

a) Communication  NO  YES, describe \_\_\_\_\_

b) Environmental  NO  YES, describe \_\_\_\_\_

c) Respiratory  NO  YES, describe \_\_\_\_\_

## 5. Does child safely and independently propel a power chair? YES NO

## HOME ACCESSIBILITY – WHERE CHILD LIVES

### 1. Where does child live?

- Private home:  Owned  Rented  Group Home  
 Apartment:  Owned  Rented  Long Term Care Facility  
 Other \_\_\_\_\_

How frequently does child leave the home?

- Daily  Several times a month  Rarely/Never

Is child's community environment wheelchair accessible? Describe where child goes:

\_\_\_\_\_  
\_\_\_\_\_

### 2. Child's Home Accessibility

- Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance

Wheelchair successfully trialed in entrances?  YES  NO

Doorway widths: Main entrance \_\_\_\_\_ Bathroom \_\_\_\_\_ Bedroom \_\_\_\_\_  
Kitchen \_\_\_\_\_ Living Room \_\_\_\_\_ Other \_\_\_\_\_

Was requested chair trialed 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? \_\_\_\_\_

### 3. Where else will this chair be used?

- a) School/University \_\_\_\_\_  
 Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance  
 Classrooms accessible  
 Bathroom accessible
- b) Other, specify \_\_\_\_\_  
 Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance
- c) Other, specify \_\_\_\_\_  
 Entrance has a lift or ramp  Lift/ramp has safe railing  Lift/ramp provides level entrance

# LIFESTYLE

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

## 2. Describe Child's Activities

a) **Education:**  YES  NO

Institution you are attending \_\_\_\_\_

Program \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

b) **Rehabilitation/training:**  YES  NO

Institution you are attending \_\_\_\_\_

Program \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

c) **Employment:**  YES  NO

Occupation/position held \_\_\_\_\_

How long in this position? \_\_\_\_\_

Full time  Part Time Hours per day or week \_\_\_\_\_

d) **Volunteer/Community Participation:**  YES  NO

1) Organization \_\_\_\_\_

Involvement \_\_\_\_\_

How long has the child been doing this? \_\_\_\_\_  Full time  Part Time

Hours per day or week \_\_\_\_\_ Supporting letter(s) attached?  YES  NO

2) Organization \_\_\_\_\_

Involvement \_\_\_\_\_

How long has the child been doing this? \_\_\_\_\_  Full time  Part Time

Hours per day or week \_\_\_\_\_ Supporting letter(s) attached?  YES  NO

**e) Recreational Activities/Socialization/Hobbies:**

This includes activities you do for fun in your home or outside of it, with your family/friends, or in your lodge/residence, in your community, in your Senior's Centre, in your church, etc.

- 1) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 2) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 3) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 4) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 5) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_
- 6) Recreation/Activity \_\_\_\_\_ Frequency \_\_\_\_\_

**f) Housekeeping/Home Management Activities (if applicable):**

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

Personal care \_\_\_\_\_

Home making \_\_\_\_\_

Other family responsibilities \_\_\_\_\_

Personal responsibilities \_\_\_\_\_

**3. Who does child live with?  Parents  Attendant  Group Home  Institution**

What assistance is needed in the home from a caregiver, and how much assistance is available to you? \_\_\_\_\_

**4. How many hours a day is power wheelchair used? \_\_\_\_\_**

**5. Client Impact Statement**

attached

The Committee would like to hear from the client/family, any information they wish to share about how a power wheelchair would affect their daily life.

## AUTHORIZER/ASSESSOR SECTION

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/anticipated changes:	
ROM upper extremity:	
ROM lower extremity:	
Strength upper extremity:	
Strength lower extremity:	
Weight:	Coordination:
Sitting endurance:	Sitting balance:
Posture:	Respiratory impairment:
Transfer ability:	Perception:
Cardiac function:	Visual ability:
Hearing:	Sensation:
Cognition:	
Ability to propel a manual wheelchair (distance):	
Smooth surface: _____ Rough outside surface: _____	
Carpet surface: _____ Slope - distance/grade: _____	
Will the client have any trouble using a power chair?	

### 2. Assessor statement

Can Applicant safely and independently use a power chair?  YES  NO

Is Applicant an active power wheelchair user?  YES  NO

### 3. Requested Power Chair

- a) Chairs trialed: \_\_\_\_\_
- b) Special features needed (include control type, tilt, recline): \_\_\_\_\_
- c) Special seating used during trial?  YES  NO
- d) Chair entered and exited home in power trial?  YES  NO
- e) Chair accessed all parts of home in trial?  YES  NO
- f) Client ability to transfer to and from power chair:
  - independent  assistive equipment used  required caregiver assistance
- g) Able to transport power chair?  YES  NO    Trialed?  YES  NO
- h) Able to access work surfaces?  YES  NO
- i) Who supplied trial chair? \_\_\_\_\_

## POWER WHEELCHAIR SPECIFICATIONS

Attached

### Note:

- AADL does not provide all the options (e.g. power tilt, power recline, environmental controls).
- The applicant must be aware that some items may be their financial responsibility.
- Successful applicants will be advised of any items which will be their financial responsibility.

1. **Why this model was chosen:** \_\_\_\_\_

2. **Is special seating required?**

Seating system (seating clinic is aware of this chair order)

Power tilt/recline

Other \_\_\_\_\_

3. **Is manual chair seating compatible?**

YES  NO

4. **Are special adaptations/accessories needed?**

Environmental control mounting equipment

Communication device mounting equipment

Oxygen holder

Vent tray

Special switches

Other \_\_\_\_\_

5. **Controls**

Joystick position:  Left  Right  Centre

Other \_\_\_\_\_

Any other information you wish to add to this application? \_\_\_\_\_

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