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Alberta Aids to Daily Living Program

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Please fill out all information. **Incomplete forms will be returned.** Applications may be submitted by mail to: Alberta Aids to Daily Living, TELUS House, 13th Floor, 10020 - 100 Street, Edmonton, Alberta T5J 0N3.

A. Client Information

Name: last first

Personal Health Number:	Birth Date:	Height and Weight:
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B. Authorizer / Assessor Information

Authorizer Name:	Authorizer Number:
Authorizer Email:	Authorizer Phone:
Additional Assessor Name (if applicable):	Assessor Phone:

C. Current Mobility Equipment

Type / Funding	Make / Model	Serial No.	Year Received
Power wheelchair <input type="checkbox"/> AADL <input type="checkbox"/> Private			
Manual wheelchair <input type="checkbox"/> AADL <input type="checkbox"/> Private			
Scooter <input type="checkbox"/> Private			

D. Clinical History

1. Diagnosis / clinical conditions:

2. Is this application for the client's **first** AADL-funded power wheelchair? Yes No
 If No, has the power wheelchair been deemed irreparable by AADL? Yes No
 If reparable, provide clinical rationale for replacement:
- _____
- _____

3. Is this a pediatric client (younger than 18 years)? Yes No

4. Is the client's **medical condition** currently stable? Yes No
If yes, how long has the client's medical condition been stable? Months or years

AADL Power Mobility Application

Client PHN: -

5. Is the client's functional status currently stable? Yes No

If **yes**, how long has the client's functional status been stable? Months or years

6. Are there any **anticipated changes** in the client's medical or functional status in the **next 12 months**? *Excluding expected childhood development.* Yes No

If **yes**, explain: _____

If **yes**, is the requested wheelchair designed to accommodate anticipated changes in the client's condition? Provide details below. Yes No

7. Does the selected power wheelchair have sufficient adjustability/adaptability to accommodate for **unanticipated** changes in the client's condition? Yes No

E. Client Capacity

8. Based on your clinical analysis, does the client possess the physical and cognitive **capacity** required to safely and efficiently operate a power wheelchair? Yes No*
*If NO, do not submit application

9. Does the client possess the physical capacity to safely **ambulate** within their **home environment**? If no, explain. Yes No
 Yes, with *cane/walker
(*May use aids for transfer purposes only)

If **Yes**, _____ metres in _____ minutes, _____ times per day

Comments: _____

9a. Current Transfer Status: _____

10. Can the client safely propel a manual wheelchair within their home environment? If no, explain. Yes, caregiver assists No

If **Yes**, _____ metres in _____ minutes, _____ times per day

Comments: _____

11. Can the client safely propel a manual wheelchair within their community environment? If no, explain. Yes No

If **Yes**, _____ metres in _____ minutes, _____ times per day

If **Yes**, has the client developed upper-extremity dysfunction due to prolonged manual wheelchair use **or** at significant risk of developing this dysfunction? Yes No

Comments: _____

AADL Power Mobility Application

Client PHN:

12. What is the client's sitting tolerance?
 In current mobility base: _____ uninterrupted hours **x** _____ times per day = _____ total hours per day
 In selected power wheelchair: _____ uninterrupted hours **x** _____ times per day = _____ total hours per day

13. Has the client demonstrated safe and efficient operation of the selected power wheelchair? Yes No*
***If NO, do not submit application**

Pediatric clients applying for their first power wheelchair may be exempt from this requirement.

If Yes, for how long: _____ hours / days (minimum trial = 24 hours cumulative)

If No and client is pediatric, describe training plan: _____

F. Accessibility

14. Where does the client live?
 Private home Condo Apartment Group home Lodge Supportive living level _____ Long-term care
 With whom does the client live? _____
 What caregiving assistance is provided and by whom? (i.e., how often, spouse, staff, homecare) _____

15. Is the client's **home environment** accessible by the requested power wheelchair? Yes No*
Accessibility must be confirmed by a home trial. ***If NO, do not submit application**

Doorway width in inches: _____ bedroom _____ kitchen _____ bathroom _____ entrance

Pediatric clients applying for their first power wheelchair may be exempt from this requirement – do have plans to consider full accessible home

16. Have the client's frequently used **community environments** been confirmed to be accessible by the selected power wheelchair? Yes No*
Accessibility must be confirmed by a trial. ***If NO, do not submit application**

17. Does the client have the means and/or reliable support to **transport** the power wheelchair to and from their home? Method to secure power wheelchair during transport has been considered. Yes No

If Yes, how: Adapted vehicle Public Transit Other: _____

If No, explain: _____

G. Care and Maintenance

18. Does the client and/or client's caregiver have means to ensure that the power wheelchair is **properly cared for and maintained**? Yes No*
***If NO, do not submit application**

What is the caregiver's relationship to the client (if applicable)? _____

Is there an appropriate, heated, indoor area to **store** the wheelchair? Yes No*
***If NO, do not submit application**

AADL Power Mobility Application

Client PHN: -

H. Client Impact – Completed by or with client (#19 to #30)

19. What **instrumental** activities of daily living will the power mobility enable the client to participate independently? **Be specific** (i.e., housework, preparing meals, grocery shopping, etc.) _____

Who currently completes instrumental ADLS? _____

20. How does power mobility enable the client to participate in **productive** activities (i.e., volunteering, employment, parenting, education)? _____

What productive activities does the client currently participate in (without power) _____

21. What **leisure** activities will the power mobility enable the client to participate in independently? Be specific.

22. What activities of daily living (ADL) will the power mobility enable the client to participate independently? Will activities increase with use of power mobility? Provide specific examples (i.e., toileting, feeding, dressing, transferring, bathing)

23. Is the client receiving any formal or informal caregiver assistance? Will caregiver assistance change with power mobility? How? _____

24. Will the client use the power mobility full time or part time? Comments: _____

25. How many days per month does the client currently go outside and into the outer community? _____ days per month. Will the client use the chair in the outer community in the winter? How? Provide specific examples. _____

26. How will the client be using the manual wheelchair? _____

27. Does the client have an AADL funded hospital bed? Yes No

28. Does the client have an AADL funded prosthetic? Yes No

AADL Power Mobility Application

Client PHN: -

I. Tilt-In-Space Documentation

31. Is the client applying for power tilt-in-space? Yes No
- If Yes** and client is an adult (age 18+), is the **Adult Power Tilt-in-Space Request form** attached? Yes No*

**Applications for power tilt will not be considered if Adult Power Tilt-in-Space Request form is not attached. AADL does not fund power tilt-in-space for pediatric clients.*

J. Specifications and Feature Restrictions

32. Are manufacturer specification forms attached? Yes No*
- *Applications without completed specification forms will be returned.*

33. Seating components – at least one box must be checked off:
- Client requires seating assessment (initial +/- or reassessment). Seating clinic to verify specifications prior to order completion. Vendor/family has agreed to store wheelchair until clinic appointment (circle one).
 - Existing seating works for client, wheelchair trialed with existing components, vendor to transfer existing seating. Specification sheets verified by authorizer.
 - Client does not need specialized seating. Specification sheets verified by authorizer.

Features NOT Funded by AADL

These features may be added to AADL power wheelchairs, but clients are responsible for their full cost.

- Pediatric power tilt-in-space
- Pediatric power recline
- Power elevating leg rests
- Light packages
- Pediatric power tilt
- Power standers
- Power seat elevator (pediatric or adult)

******Head-arrays are available as a one-time grant of \$4,000. Repairs on the head-array are client's responsibility.

Frame Color Restrictions

AADL provides power wheelchairs with black or blue frames. Other frame colors are not available.

Client Impact Statement

Attach to application if required.

