pertan

Protected A (when completed)

Alberta Aids to Daily Living Program

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the Health Information Act, sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act* (FOIP) and the Alberta Aids to Daily Living and Extended Health Benefits Regulations for the purpose of obtaining an AADL benefit. If you have any questions about the collection of this information, you can contact the Alberta Aids to Daily Living Program at TELUS House, 13th Floor, 10020 100 Street NW, Edmonton, AB T5J 0N3; Telephone: 780-427-0731, Fax: 780-422-0968.

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

Nar	ne:	last		first		
Personal Health Number:		Birth Date:		Height and Weight:		
В.	Authorizer / Assessor	Information		'		
Aut	norizer Name:			Authorizer Number:		
Aut	norizer Email:			Authorizer Phone:		
Add	itional Assessor Name (if	applicable):		Assessor Phone:		
С.	Current Mobility Equip	ment				
	Type / Funding	Make / Model		Serial No.	Year Received	
Pov	ower wheelchair □ AADL □ Private					
Manual wheelchair AADL Private						
Sco	Scooter					
D.	D. Clinical History					
1.	1. Diagnosis / clinical conditions:					
2.	Is this application for the	client's first AADL-funded power v	vheelchair?	□ 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	

AA	DL Power Mo	obility Application		Client PHN:		-	
	5. Is the client's	s functional status currer	ntly stable?		□ Yes	□ No	
	lf yes, how lon	g has the client's functio	nal status been stable	?	Months or	years	
6.		nticipated changes in the nths? Excluding expect			□ Yes	□ No	
	lf yes , explain:						_
		equested wheelchair des client's condition? Provi		e anticipated	Yes	□ No	
7.		ed power wheelchair hav or unanticipated change			Yes	□ No	
Ε.	Client Capacit	ty					
8.		clinical analysis, does the ed to safely and efficient				□ No* t submit application	
9.	9. Does the client possess the physical capacity to safely ambulate within their home □ Yes □ No environment? If no, explain. □ Yes, with *cane/walke (*May use aids for transfer pu				n *cane/walker	s only)	
	lf Yes,	metres in	minutes,	times	per day		
	Comments:						_
9a	9a. Current Transfer Status:						
10.	Can the client environment?	safely propel a manual w If no, explain.	vheelchair within their	home	☐ Yes, care assists	egiver □ No	
	lf Yes,	metres in	minutes,	times	per day		
	Comments:						
11.		safely propel a manual v vironment? If no, explair			□ Yes	□ No	
	lf Yes,	metres in	minutes,	times	per day		
		client developed upper- chair use or at significant			□ Yes	□ No	
	Comments:						_

AADL Power Mobility Application Client PHN:	
 12. What is the client's sitting tolerance? In current mobility base:uninterrupted hours xtimes per day = 	total hours per day
In selected power wheelchair:uninterrupted hours xtimes 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 the second sec	urs cumulative)
F. Accessibility	
14. Where does the client live? Private home Condo Apartment Group home Lodge Supportive With whom does the client live? What caregiving assistance is provided and by whom? (i.e., how often, spouse,	
15. Is the client's home environment accessible by the requested power wheelchair <i>Accessibility must be confirmed by a home trial.</i>	ir? □ Yes □ No* *If NO, do not submit application
Doorway width in inches:bedroomkitchenbathroo Pediatric clients applying for their first power wheelchair may be exempt from th consider full accessible home	
16. Have the client's frequently used community environments been confirmed t be accessible by the selected power wheelchair?	o □ Yes □ No* *If NO, do not submit application
Accessibility must be confirmed by a trial.	
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.	
If Yes , how:	
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? What is the caregiver's relationship to the client (<i>if applicable</i>)?	☐ Yes ☐ No* *If NO, do not submit application
Is there an appropriate, heated, indoor area to store the wheelchair?	☐ Yes ☐ No* *If NO, do not submit application

AA	DL Power Mobility Application	Client PHN:				
н.	Client Impact – Completed by or with client (#19 to #30)					
19.	9. 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 prod 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	o participate in independently? Be specific.				
22	2. What activities of daily living (ADL) will the power mobility enab increase with use of power mobility? Provide specific examples					
23	3. Is the client receiving any formal or informal caregiver assistant mobility? How?					
24	4. Will the client use the power mobility full time or part time? Con	nments:				
25	5. How many days per month does the client currently go outside month.Will the client use the chair in the outer community in the examples.	winter? How? Provide specific				
26	6. How will the client be using the manual wheelchair?					
27	7. Does the client have an AADL funded hospital bed? □Yes	□ No				
28	3. Does the client have an AADL funded prosthetic? □Yes	□ No				

AADL Power Mobility Application

Client PHN:

-

29. Within the last 6 months, please describe the client's lifestyle prior to the change in condition/need for power mobility.

30. Please use this area to add any additional information to any question or any other comments you would like to make:

AA	DL Power Mobility Application	ı	Client PHN:		-	
I.	Tilt-In-Space Documentation					
31.	Is the client applying for power tilt-in-s	pace?		□ Yes	No	
	If Yes and client is an adult (age 18+ Request form attached?), is the Adult Power	Tilt-in-Space	□ Yes	No*	
	*Applications for power tilt will not be attached. AADL does not fund powe			equest form is i	not	
J.	Specifications and Feature Restric	tions				
32.	Are manufacturer specification forms *Applications without completed spe		returned.	□ Yes	□ No*	
 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 AA	DL power wheelchairs	but clients are respo	onsible for their	full cost.	
	 Pediatric power tilt-in-space 	Pediatric power	recline	 Power elevation 	ting leg rests	
	 Light packages 	Pediatric power	tilt	Power stan	ders	
	• Power seat elevator (pediatric or a	dult)				
	**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 wit	h black or blue frames	. Other frame colors a	are not availab	e.	

Client Impact Statement

Attach to application if required.

Client Name

AADL Power Mobility Application Client PHN:

K. Client Declarations

Ι,

hereby declare the information contained with this application to be

true and accurate to the best of my knowledge. I confirm that:

- □ My authorizer and assessor(s) have explained AADL's policies and procedures to me.
- □ I agree with the specifications and features of the power wheelchair being requested.
- □ I confirm that all environments and locations in which I will need to use the power wheelchair are accessible.
- □ I agree that the requested features meet my basic needs.
- □ I understand that I am not eligible for replacement of my power wheelchair until my current power wheelchair is no longer cost effective to repair.
- □ I understand that AADL will not automatically provide a replacement power wheelchair. I will need to complete a new application form to demonstrate that I continue to meet AADL's eligibility criteria.
- □ I understand that if this application is approved, the power wheelchair that I get **may be new or recycled**.
- □ I am satisfied with the requested model and confirm it will meet my needs.

Client / Authorized guardian/trustee signature

Date (yyyy-mm-dd)

Financial Considerations:

- □ I understand that I am responsible for the care and maintenance of the power wheelchair, and that I am responsible for replacement of the wheelchair if it is lost, stolen or damaged due to misuse.
- □ I am aware that AADL recommends obtaining insurance coverage for power wheelchairs.
- □ I understand that AADL will assist with costs to repair and maintain the power wheelchair but that I am responsible to ensure the wheelchair is available for the vendor when needed.
- □ I understand that I am responsible for the cost of any repairs on any upgraded parts or add on parts that are not funded by AADL.
- I understand that AADL will not fund duplicate equipment. This means if I currently have specialized seating equipment in my manual wheelchair and it cannot transfer to the power wheelchair, I am responsible for the costs of the duplicate equipment.
- □ I understand AADL has a repair limit; repairs over this limit are my financial responsibility.

Client / Authorized guardian/trustee signature

Date (yyyy-mm-dd)

AADL Power Mobility Application	Client PHN:
L. Authorizer Declaration	
I,hereby de Authorizer Name true and accurate to the best of my knowledge. I confirm that:	clare the information contained with this application to be
 I have explained AADL's policies and procedures to the clien I have gone over the client declaration with the client, or the understands his/her responsibilities. I confirm the details of the clinical assessment. 	
I confirm the client has had the opportunity to trial the power	wheelchair in all pertinent environments and locations.
I agree that the requested features meet the client's basic n	eeds.

- □ I have advised the client of any costs they are responsible for, including cost-share and upgrade charges.
- □ I have read and understand the information on the Power Mobility Application form.
- □ I understand that if this application is approved, the power wheelchair the client receives **may be new or recycled**.

Authorizer signature		Date (yyyy-mm-dd)		
Please indicate: Clie	nt's preferred vendor and s			
FOR AADL USE ONLY				
Application Screen:	D PM – APPROVED	D PM – DENIED		
Date:			Initials	