### Client Information

<table>
<thead>
<tr>
<th>Name: last first</th>
<th>PHN:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Birth Date:</th>
<th>Height and Weight:</th>
<th>1251 Form #:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Authorizer / Assessor Information

<table>
<thead>
<tr>
<th>Authorizer Name:</th>
<th>Authorizer Number:</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Authorizer Email:</th>
<th>Authorizer Phone:</th>
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<table>
<thead>
<tr>
<th>Additional Assessor Name (if applicable):</th>
<th>Assessor Phone:</th>
</tr>
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</table>

### Current Mobility Equipment

<table>
<thead>
<tr>
<th>Type / Funding</th>
<th>Make / Model</th>
<th>Serial No.</th>
<th>Year Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Wheelchair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ AADL □ Private</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual Wheelchair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ AADL □ Private</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scooter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Private</td>
<td></td>
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### 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 / years (Circle one)

5. Is the client’s **functional status** currently stable? □ Yes □ No

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### AADL Power Mobility Application

If Yes, how long has the client’s functional status been stable? ________________ months / years  
(Circle one)

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

If Yes. ____________ metres in ____________ minutes, ____________ times per day  
Comments: ________________________________________________________________________________  
__________________________________________________________________________________________  
__________________________________________________________________________________________

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

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: ________________________________________________________________________________  
__________________________________________________________________________________________  
__________________________________________________________________________________________
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)

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

F. Accessibility

14. Where does the client live (for example private home, Long-term care facility, etc.)?
________________________________________________________________________________________

15. Is the client's home environment accessible by the requested power wheelchair?

☐ Yes  ☐ No*

*If NO, do not submit application

Accessibility must be confirmed by a home trial.

Doorway width in inches: ______ bedroom _______ kitchen _______ bathroom ______ entrance

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

16. Have the client's frequently used community environments been confirmed to be accessible by the selected power wheelchair?

☐ 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.

☐ 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)
## AADL Power Mobility Application

**Client PHN:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Indoors</th>
<th>Outdoors</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an appropriate, heated, indoor area to store the wheelchair?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*If NO, do not submit application</td>
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</tbody>
</table>

### H. Client Impact – Completed by or with client (#19 to #23)

**19.** Is power mobility the **only** intervention that enables the client to participate independently in **instrumental** activities of daily living? (e.g. house work, shopping)

- Indoors: ☐ Yes ☐ No ☐ N/A
- Outdoors: ☐ Yes ☐ No ☐ N/A

Describe alternate mobility strategies attempted, and why they did not enable participation: ____________________________

________________________________________________________________________________________

If n/a, explain: ____________________________________________________________________________

**20.** Is power mobility the only intervention that enables the client to participate independently in **productive** activities of daily living? (e.g. employment, education, parenting, volunteering)

- Indoors: ☐ Yes ☐ No ☐ N/A

Describe alternate mobility strategies attempted, and why they did not enable participation: ____________________________

________________________________________________________________________________________

If n/a, explain: ____________________________________________________________________________

**21.** Is power mobility the only intervention that enables the client to participate independently in **leisure** activities of daily living? (e.g. socialization, recreation, entertainment).

- Indoors: ☐ Yes ☐ No ☐ N/A

Describe alternate mobility strategies attempted, and why they did not enable participation: ____________________________

________________________________________________________________________________________

If n/a, explain: ____________________________________________________________________________

**22.** Will power mobility increase client participation in **basic self-care** activities of daily living? (e.g. dressing, feeding, bathing, toileting)

- Indoors: ☐ Yes ☐ No ☐ N/A

Explain: __________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**23.** Briefly Describe Daily Usage Plan for Power Mobility.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
### AADL Power Mobility Application

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Does the client have realistic goals for increasing participation in the community with the power wheelchair?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>25. Is the client motivated to increase his/her independence in activities of daily living with the power wheelchair?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>26. Will power mobility increase the client's frequency of participation in productive or leisure activities of daily living?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If Yes, how many days per month can the client participate in productive or leisure activities **without** power mobility?

_______ total days per month

If Yes, how many days per month will the client be able to participate in productive or leisure activities **with** power mobility?

_______ total days per month

### Tilt-In-Space Documentation

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Is the client applying for power tilt-in-space?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If Yes and client is an adult (age 18+), is the **Adult Power Tilt-in-Space Form** attached?

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

### Specifications and Feature Restrictions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Are manufacturer specification forms attached?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*Applications without completed specification forms will be returned.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Seating Components – at least one box must be checked off:</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- ☐ Client requires seating assessment (initial +/- 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 $1500. 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.
K. Client Declarations

I, ___________________________ 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/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 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/Guardian/Trustee Signature ___________________________ Date (yyyy-mm-dd)
I, ____________________________ hereby declare the information contained with this application to be true and accurate to the best of my knowledge. I confirm that:

☐ I have explained AADL’s policies and procedures to the client.
☐ I have gone over the client declaration with the client or the person responsible for the client and he/she 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 needs.
☐ 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 “Updated Information about 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: Client’s Preferred Vendor and Sales Representative

FOR AADL USE ONLY

Application Screen:  ☐ PM – APPROVED  ☐ PM – DENIED

Date: ____________________________  Initials ____________________________