Accessibility Supports
Equipment Loan Program Application

Occupational or Physiotherapist Assessment

To be completed by the applicant's Occupational or Physiotherapist. Please complete this form for power mobility and hospital bed equipment requests as well as Give a Kid a Lift program applications.

Easter Seals Alberta requires an Occupational or Physiotherapist assessment be completed in conjunction with the Equipment Loan Program Client Application and Give a Kid a Lift Application when applying for assistance in obtaining mobility equipment.

Based on the applicant's needs, lifestyle, and living situation, please include your recommendation(s) for the equipment that will best meet the applicants basic needs and provide a specific rationale to support your recommendation(s).

Easter Seals Alberta will provide a maximum of $5,000.00 in funding towards power mobility or hospital bed equipment. If an applicant's equipment funding request exceeds this amount, it is the applicant's responsibility to secure funding for the remaining cost. Funding requests that are $5,000.00 or less are not guaranteed to be approved.

Due to the high volume of requests and limited funding, wait times to receive equipment may vary.

The information provided in this document is for the purposes of determining eligibility for assistance through Easter Seals Alberta. The information collected will be held in strict confidence and used only for the purpose for which it is intended.

Please note that the applicant is responsible for costs associated with completing this form.

Please submit this form to accessibilitysupports@easterseals.ab.ca or to the mailing address listed at the bottom of the page. **When submitting this form to the above email address, please include the applicants FIRST and LAST name in the file name.**

Applicant Information

Name: _____

Phone number: _____ Email: _____

Primary medical diagnosis: _____

Other relevant medical/physical conditions:

Prognosis: _____

Height _____ Weight: _____

Description of disability (strength, balance, endurance, hand function, level of independence, transfers, etc. as relevant to the equipment recommended:

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Applicant's Mobility

What is the applicant's primary method of mobility?

Unassisted ☐ Cane/crutches ☐ Walker ☐ Manual wheelchair ☐ Power mobility ☐

What difficulty is the applicant having with this method?

Which power mobility aid(s)(make and model) has the applicant tried during assessment?

Vendor Name: _____

Where and for what time period was the power mobility aid(s) trialed?

Specific make and model recommended and why?

How often, where and for what activities would applicant use mobility device?

Please provide rationale behind the choice of a 3 or 4 wheel scooter (if applicable):

How long do you believe the applicant would be able to use the equipment? _____

Equipment Specifications

Types of controls: Right ☐ Left ☐ Center ☐ Head ☐ Other☐ _____

Seat Size: _____ Seat type: _____

Seating tolerance: _____

Any disability that would impact the type of seat or locking mechanism required? _____

Has a referral been made to a seating clinic, if necessary? _____

Physically necessary adaptations and or accessories required (i.e. cane holder, suspension, oxygen tank holder, delta tiller, etc.)?

_____

Applicant Suitability and Responsibility

Is the applicant able to do their own maintenance (i.e. battery charging, light maintenance, cleaning, etc.)? _____

If assistance is required, is it available and by whom? _____

Transportation of equipment will be by:

- ☐ Applicant's vehicle – Year/ make and model: _____
  Will applicant be driving vehicle? Yes ☐ No ☐
  List adaptations required: _____
- ☐ Specialized parallel transit (ie. DATS, Access)
- ☐ Low floor bus
- ☐ None Required

Please note: If the client intends on taking the equipment on transit, it is recommended to trial the equipment on transit first.

Home Accessibility

Type of dwelling: _____

Is the home wheelchair/scooter assessable? Yes ☐ No ☐

Are there any ramps or lifts? Yes ☐ No ☐ Where? _____

Where will the equipment be stored and charged? _____

If the applicant rents their home, does the applicant have landlord approval for storing the mobility aid in their suite? Yes ☐ No ☐

Safety

Does the applicant have a visual, cognitive, or physical impairment that would risk their safety, safety of others, or risk damage to property if they were using the mobility aid?

If training is required to safely use the mobility aid, who will do it? _____

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Did you encounter any problems or difficulties during the trial of the equipment?

Final Impressions

Please provide any final impressions or additional comments here:

If this request is for a power wheelchair, has the client been denied by Alberta Aids to Daily Living? If so, why and has the decision been appealed? Please enclose a copy of the letter(s) of denial.

Name of Therapist: _____ Phone: _____
(please print)

Address: _____ Fax: _____

Email: _____ Date: _____

Signature: _____

Any personal information that Easer Seals Alberta may collect is collected in compliance with section 33 (c) of the Freedom of Information and Protection of Privacy (FOIP) Act. The information collected is limited to what is necessary for determination of eligibility for benefits and programs. This information and all associated records and files shall remain under control of Alberta Seniors & Community Supports ministry and will be provided to them upon their request. All reasonable efforts shall be taken against such risks as unauthorized access, collection, use, disclosure, disposal and disaster. For any questions or concerns about the collection, use and disclosure of personal information, please contact Easter Seals Alberta.