Accessibility Supports Equipment Loan Program
Occupational Therapist Assessment

To be completed by the applicant's occupational therapist. Please complete this form for all equipment requests

Easter Seals Alberta may provide a maximum of $5,000.00 in funding towards one piece of equipment.
If an applicant's equipment funding request exceeds this amount, it is the applicant's responsibility to secure funding for the remaining cost. Due to the high volume of requests and limited funding, wait times to receive equipment may vary. If the client's application is denied, they may reapply one year from the date on their denial letter. If they are approved, they are eligible for one piece of equipment every five years.
We **do not** rush applications or move clients ahead on the list.

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

If this application is for power mobility (power wheelchair, power scooter, etc.), please go to page 2.

If this application is for all other equipment (lifts, lift assist chairs, hospital beds, tracks, ramps, elevating seats, walking aides, etc.), please go to page 4.

If you need to be present for delivery, please coordinate with the client. Easter Seals and our vendors cannot coordinate delivery with multiple parties.

Applicant Information

Name: _____ Phone number: _____

Email: _____ Height: _____ Weight: _____

Medical Information

Primary medical diagnosis: _____

_____

Prognosis of disability (please check all that apply)**:** Permanent ☐ Long Term ☐ Progressive ☐
Likely to Improve with Treatment ☐ Degenerative ☐ Terminal ☐ Other (please specify): _____

Other relevant medical/physical conditions:

Description of disability as relevant to the equipment recommended: Low Upper Body Strength ☐

Low Lower Body Strength ☐ Low Total Body Strength ☐ Balance Issues ☐ Lack of Endurance ☐

Difficulties Sitting/Standing Up ☐ Difficulties Transferring Into/Out of Bed ☐ Fine Motor Difficulties ☐

Gross Motor Difficulties ☐ Lack of Independence ☐ Coordination Issues ☐ Mobility Difficulties ☐

Other (please explain): _____

Equipment Requested

Power Mobility: Mobility Scooter ☐ Power Wheelchair ☐ Other: _____

Lift Devices: Vertical Lift ☐ Porch Lift ☐ Stair Lift ☐ Other: _____

Other : Hospital Bed ☐ Elevating Seat ☐ Ceiling Tracks ☐ Stroller ☐ Portable Ramp ☐ Lift Assist Chair ☐

Other:_____

Please submit applications to **accessibilitysupports@easterseals.ab.ca**
Phone: 403.235.5662 ext 1 Fax: 587.391.1751 101, 340 Midpark Way SE Calgary AB T2X 1P1

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Home Accessibility

Type of dwelling: Single Level Home ☐ Multi-level Home ☐ Townhouse ☐ Condo ☐ Apartment ☐

Mobile Home Assisted Living ☐ Other (please explain) ☐:_____

Wheelchair/scooter accessible: Yes ☐ No ☐

Ramps/Lifts: Yes (where) ☐: _____ No ☐

Where will the equipment be stored and charged? (Adequate storage is a requirement for approval)

_____

Landlord approval for storage or installation? Yes ☐ No ☐

AADL/AISH Requests: Has the equipment been applied for through AADL/ AISH for this Yes ☐ No ☐

If yes, was the client approved or denied: Approved ☐ Denied (why)☐:_____

POWER MOBILITY- Only complete for Power Mobility Requests

Applicant's Mobility

Unassisted ☐ Cane/Crutches ☐ Walker ☐ Manual Wheelchair ☐ Power Wheelchair ☐

Other (please explain) _____

What difficulty is the applicant having with this method?

Which power mobility aid(s) (make and model) has the applicant tried during assessment?
(Please note, a trial of the equipment is mandatory to ensure a proper fit to the client/needs/lifestyle)

Vendor: _____ **Time Period of Trial:** _____

Where was the power mobility aid(s) trialed?
In home ☐ In Community ☐ At Vendor ☐ Details: _____

Specific make and model recommended and why?

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How would the requested equipment benefit the applicant?

Independence ☐ Reduced pain ☐ Improved Balance ☐ Improved Coordination ☐ Improved Stability ☐

Getting Out and About ☐ Running Errands ☐ Attending Appointments ☐ Easier Travel ☐ Less Stress ☐

Mental Health ☐ Attending school / work ☐ Volunteering ☐

Other (please explain): _____

Where would the applicant use the power mobility device?

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

Does the client have any specific equipment specification needs?

SAFETY & SUITABILITY

Applicant Suitability and Responsibility

Is the applicant able to do their own maintenance (i.e., battery charging, light maintenance, cleaning, etc.)? Yes, all of it☐ Yes, some of it☐ No, none of it☐

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

Please note: The cost of maintenance of equipment provided through this program is the responsibility of the client

Clients mode of Transportation:

Drives ☐ Relative/Friend ☐ Public Transportation ☐ Specialized Transportation (Access/ DATS) ☐

Other:_____

If the client intends on taking the equipment on transit, if possible, trial the equipment on transit.

Safety

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

No ☐ Yes, Visual ☐ Cognitive ☐ Physical ☐

If yes, please explain: _____

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Is safety training required:

No ☐ Yes ☐ (please explain): _____

_____

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

No ☐ Yes ☐(please explain): _____

ALL OTHER EQUIPMENT

Equipment Requested

Vertical lift ☐ Porch lift ☐ Stair lift ☐ Hospital bed ☐ Elevating seat ☐ Ceiling tracks ☐ Stroller ☐

Portable ramp ☐ Lift assist chair ☐ Other: _____

How Applicant Will Benefit from the Requested Equipment:

Home accessibility ☐ Safety ☐ Increased independence ☐ Greater confidence ☐

Better balance/coordination ☐ Easier self-care tasks (i.e., dressing, washing, eating, etc.) ☐

Improved Mental Health ☐ Caregiver safety ☐ Other, please explain:_____

Final Impressions (all equipment)

Other Relevant Information: Is there anything else you would like to explain in regard to the equipment requested? If so, please explain in the provided space below:

Name of Therapist: _____ Phone: _____

Email: _____

Alternate OT Contact: _____ Phone:_____

Email:_____

Date: _____ Signature: _____

Any personal information that Easter 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.

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