Easter Seals Nova Scotia
22 Fielding Ave. Dartmouth NS B3B 1E2
wheelchairs@easterseals.ns.ca
(902)453-6000 ext. 229

NOVA SCOTIA WHEELCHAIR RECYCLING PROGRAM APPLICATION FORM

READ THIS FIRST: Before starting this application form, please read the **PROGRAM ELIGIBILITY CRITERIA** carefully.

The following conditions must be met in order for the applicant to qualify for the NS Wheelchair Recycling Program

The Applicant Must:

I. Complete all sections of this Application Form (**SECTIONS A, B,C, and D**)
II. Must be an active client of the Department of Community Services
III. Be under 65 years of age
IV. Be a permanent resident of Nova Scotia
V. Provide a valid Nova Scotia Health Insurance number
VI. Provide the NS Wheelchair Assessment Form (pages 9, 10 only) from an Occupational Therapist or attending health care professional (attached to this application)
VII. Provide two quotes with this application outlining the prescribed needs
VIII. Provide the specifications (order form) of requested wheelchair

IMPORTANT NOTES:

I. Funding consideration of a new wheelchair is limited to one new wheelchair every five years.
II. If a suitable refurbished chair is available, it will be considered first (this includes dealer demo's).
III. Any co-payment required from the applicant must be provided to the vendor before receiving the wheelchair.

SECTION A: CLIENT INFORMATION

Name _____ Date of Birth _____YYYY/MM/DD_____

Address _____ Telephone _____

_____

Health Card Number _____

Name of Applicants Department of Community Services Caseworker

_____

Phone # _____ Fax # _____

Is there other insurance coverage available? Y ☐ N ☐
(Please attach assessment of claim)

For applicants aged 18 years and under, please provide name(s) of parent(s)/guardian(s)

_____

SECTION B: EQUIPMENT INFORMATION

Current Equipment _____

Date Obtained _____ Supplied By _____

Why is it no longer appropriate? _____

_____

_____ Being returned to ESNS Y ☐ N ☐

If client currently has more than one wheelchair please list make, model and year.

_____

SECTION C: MEDICAL INFORMATION

Applicant Diagnosis _____

REFERRING OCCUPATIONAL THERIPIST

Name _____

Telephone # _____ Fax # _____

E-mail _____

Signature _____ Date _____

SECTION D: ATTACHMENTS

Please ensure the following are attached to application:

Application Form Completed And Signed ☐ NS Wheelchair Assessment Form (pages 9, 10 only) ☐

Two Quotes From Vendors ☐ Equipment Specifications/Order Form ☐

Insurance Assessment (if applicable) ☐

PLEASE NOTE: *FINANCIAL CONSTRAINTS HAVE LIMITED THE AMOUNT OF FUNDING AVAILABLE. CONSIDERATION OF THE APPLICANT''S NEED AND POTENTIAL REFURBISHMENT OF A USED WHEELCHAIR WILL BE CONSIDERED FIRST.*

PLEASE RETURN COMPLETED APPLICATION FORM AND ALL ADDITIONAL DOCUMENTATION TO:

Mailing Address:
Nova Scotia Wheelchair Recycling Program
c/o Easter Seals Nova Scotia
22 Fielding Ave. Dartmouth NS B3B 1E2

E-mail
wheelchairs@easterseals.ns.ca

Fax
(902) 454-6121

Applicant agrees:

1. Ownership of the wheelchair resides with Easter Seals Nova Scotia
2. To return the wheelchair to Easter Seals Nova Scotia when it is no longer required
3. To respond to enquiries from Easter Seals NS in a timely fashion regarding the current wheelchair location, condition, usage and repairs
4. To keep the wheelchair in good working order.

IMPORTANT NOTES:

- Limited funding may be available for repairs not covered under warranty
- Applicant must have wheelchair supplier contact Easter Seals NS before repairs are approved

Applicant Authorization:

I hereby authorize Easter Seals Nova Scotia to conduct such enquiries as it may deem necessary, including contact with my health practitioner, financial institutions, insurance providers or other referees.
I hereby authorize such health practitioners, financial institutions, insurance providers, or other referees to release such information regarded as pertinent to my application. I understand all information presented here will be held in the strictest of confidence by Easter Seals NS and Program Partners, NS Dept. of Community Services. Some information may be used for statistical purposes, with no individual identities being disclosed to the public.

Signature of Applicant
Or Parent/Guardian:_____

Date: _____

Nova Scotia

Provincial Seating and Mobility Assessment

World Health Organization – Wheelchair Service Provision Steps

❑ 1. Referral and Appointment ☑ **3. Prescription** ❑ 5. Wheelchair Preparation ❑ 7. Training
❑2. Assessment ☑ **4. Funding & Ordering** ❑ 6. Fitting ❑ 8. Maintenance & Follow-up

Wheelchair User Name: _____ **HCN:** _____

Date (yyyy/mm/dd):_____

☐ Informed consent to provide Care Coordinator and Vendor with equipment prescription form

☐ Client and/or Authorized Representative aware and in agreement with equipment prescription

☐ Manufacturer's order form attached

Wheelchair Equipment Prescription	
Base Manual ☐ Folding ☐ Non-folding Power ☐ Rear-wheel ☐ Mid-wheel ☐ Front-wheel ☐ Power assist	Type: Width: Depth: Height:
Positioning Components ☐ Tilt ☐Manual ☐Power ☐ Other: _____	Type: ☐ Not Applicable
Input Device	Type: ☐ Not Applicable Location:
Critical Angles Seat to Back: Foot rests:	
Armrests	☐ Not Applicable
Footrests and Plates	☐ Not Applicable
Tie Downs	☐ Not Applicable

Wheelchair User Name: _____ **HCN:** _____

Cushion	Type: Width: Depth:	☐ Not Applicable
Back	Type: Width: Height:	☐ Not Applicable
Pelvic Support	Type:	☐ Not Applicable
Headrest	Type: Mounting hardware:	☐ Not Applicable
Additional Positional Supports		☐ Not Applicable
Accessories		☐ Not Applicable

Plan:

☐ Vendor to contact therapist when equipment available for fitting.

☐ Therapist to complete visit with the client and vendor for fitting and set-up of wheelchair.

☐ Therapist to provide training and follow-up once wheelchair in place.

_____

_____

_____

_____

_____

Therapist Signature: _____

Name printed: _____

Contact #: _____

CC: Health Records
Care Coordinator
Vendor