



Active Living
Assistive Devices
Family & Community Support



Nova Scotia

3670 Kempt Road, Halifax NS B3K 4X8
Tel: 902-453-6000, ext 229; Fax: 902-454-6121
Toll Free 1-866-554-4527
Email: wheelchairs@easterseals.ns.ca

NOVA SCOTIA WHEELCHAIR RECYCLING PROGRAM APPLICATION FORM - 2011

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

PROGRAM ELIGIBILITY CRITERIA

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The following conditions must be met to complete this application and qualify for the NS Wheelchair Recycling Program:

The Applicant must:

- I. complete all sections of this Application Form (**SECTIONS A, B and C**)
- II. be under 65 years of age
- III. not have additional coverage through public programs or private insurance ¹
- IV. be a permanent resident of Nova Scotia
- V. provide a valid Nova Scotia Health Insurance number
- VI. provide most recent Family Income/Proof of Income ² & Notice of Assessments (NOA) from Canada Revenue Agency (CRA) ³
- VII. provide the prescription from an Occupational Therapist or attending health care professional (attached to this application)
- VIII. provide two quotes with this application outlining the prescribed needs
- IX. provide co-payment amount (where applicable) to the retail supplier before receiving the wheelchair ⁴

IMPORTANT NOTES:

- 1 Applicant may receive special consideration for wheelchair funding if applicant otherwise qualifies under the Wheelchair Recycling Program criteria, except **PROGRAM ELIGIBILITY CRITERIA** clause *III.* above. For additional details, see **SPECIAL EXEMPTION - INSURANCE CLAUSE EXCLUSION** (Page 3).
- 2 Applicant Family Income/Proof of Income is limited to those earning prescribed maximums annually, as verified by the individual's most recent NOA (Form T451 E received after filing tax information)" from CRA. Proof of Net Income must be provided.
- 3 If the applicant is a Department of Community Services client and the Department of Community Services case manager contact information is provided then the income information does not need to be provided
- 4 See **INCOME ELIGIBILITY AND CO-PAYMENT SCHEDULE** (Page 5) for full eligibility criteria and co-payment amounts.
5. Funding consideration of a new wheelchair is limited to one new wheelchair every five years.

SECTION A: APPLICANT INFORMATION

First Name: Date of Birth: / /
 (MM/DD/YYYY)

Last Name: NS Health Card Insurance Number:

Address:
 (Street or Apartment No.) (Town/City/Community)

Postal Code: Phone #: (902)

For applicants aged 18 years and under, please provide name(s) of Parent(s)/Guardian(s):

Number of immediate family members living in the household? (fill in A. or B. but not both):

A. Applicant's over 18 years- include applicant plus spouse/partner if applicable:

B. Applicant's aged 18 & under - number of dependent children in family, including applicant:

Name of Applicant's Department of Community Services Case Manager:

Phone #: () - Fax #: () -

Do you have health insurance coverage for a wheelchair (check Yes or No)? YES NO

If Yes: Please attach Health Insurance Policy and related information detailing the coverage provided by the policy and continue to **SECTION B: APPLICANT AUTHORIZATION.**

If No: Continue to **SECTION B: APPLICANT AUTHORIZATION.**

SECTION B: APPLICANT AUTHORIZATION**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 the 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 Nova Scotia. Some information may be used for statistical purposes, with no individual identities being disclosed to the public.

Signature of Applicant**or Parent/Guardian:** _____ **Date:** _____**SPECIAL EXEMPTION - INSURANCE CLAUSE EXCLUSION***(Effective March 2009)***Exemptions Criteria:**

Any applicant who otherwise qualifies under the Wheelchair Recycling Program criteria, except as related to the Insurance Clause Exclusion, may receive special consideration for wheelchair funding if they qualify under the following criteria:

1. The applicant has largely depleted the available wheelchair insurance funding provided for by their insurance policy.
2. If the outstanding amount of the funding being sought by the applicant to address the insurance coverage shortfall is 25% or more of their reported annual family income, the applicant will be considered for funding for the outstanding amount of the cost of the prescribed wheelchair and seating.
3. Such funding would be less any co-payment that may be required based on the total wheelchair quoted cost by the vendor. Any co-payment required from the applicant must be provided to the vendor before receiving the wheelchair.
4. Funds are provided on a first come, first serve basis until the Wheelchair Recycling Program special consideration budget allocation is depleted for the current fiscal year.

SECTION C: TO BE COMPLETED BY OCCUPATIONAL THERAPIST OR PRESCRIBING HEALTH PROFESSIONAL

Name of Occupational Therapist/Prescribing Health Professional:

Phone #: () - - - -

Fax #: () - - - -

Email: @ . . .

Please provide the following Applicant information:

Applicant's Diagnosis: _____

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.

1st Priority - Refurbishment/Recycling:

1. If the applicant has an existing chair, could it be adapted to meet his/her current needs? YES NO

2. Is a suitable refurbishment available that meets the requirements of the prescription, extends the useful life of the wheelchair for at least 2 years, and the end cost of the recycling is no more than 30% of the cost of a comparable new wheelchair? YES NO

NOTE: If a price quote for refurbishment has been secured - only one is needed and please attach.

3. Identify the sources contacted to determine if a recycled wheelchair is available: _____

Financial Assistance Impact:

1. Is the Applicant's need for a wheelchair limiting discharge from a hospital? YES NO

2. Without financial assistance, are there safety issues for the applicant ensuring a minimum level of independence? _____ YES NO

3. Without financial assistance, are there safety issues for the applicant's caregiver? _____ YES NO

4. Does the applicant have other means of mobility? (eg. existing chair, scooter, etc) _____ YES NO

PLEASE RETURN COMPLETED APPLICATION FORM AND ALL ADDITIONAL DOCUMENTATION TO:

Mailing Address: Nova Scotia Wheelchair Recycling Program
c/o Easter Seals Nova Scotia
3670 Kempt Road, Halifax NS B3K 4X8

Fax # : 902-454-6121

INCOME ELIGIBILITY AND CO-PAYMENT SCHEDULE

For Applicants aged 18 Years and Under - include the Parent(s)/Guardian(s) Notice of Assessments
(Effective November 2009)

REQUIRED CO-PAYMENT PERCENTAGE & (MAXIMUM CO-PAYMENT) OF WHEELCHAIR COST ²					
Family ¹ Annual Net Income	Number of Immediate Family Members Living in the Household				
	1 Adult 1 Child	1 Adult 2 Children	2 Adults 1 Child	2 Adults 2 Children	2 Adults 3 or more Children
Under \$20,000	No co-pay	No co-pay	No co-pay	No co-pay	No co-pay
\$20,001 to \$25,000	5% (max \$250)	No co-pay	No co-pay	No co-pay	No co-pay
\$25,001 to \$31,440	5% (max \$500)	5% (max \$250)	5% (max \$250)	No co-pay	No co-pay
\$31,440 to \$36,672	10% (max \$750)	5% (max \$500)	5% (max \$500)	5% (max \$250)	No co-pay
\$36,743 to \$41,904	10%	10% (max \$750)	10% (max \$750)	5% (max \$500)	5% (max \$250)
\$41,905 to \$47,136	15%	10%	10%	10% (max \$750)	5% (max \$500)
\$47,137 to \$55,000	20%	15%	15%	10%	10% (max \$750)
\$55,001 to \$65,000	25%	20%	20%	15%	10%
\$65,001 to \$75,000	Not Eligible	25%	25%	20%	15%
\$75,001 to \$85,000	Not Eligible	Not Eligible	Not Eligible	25%	20%
\$85,001 to \$90,000	Not Eligible	Not Eligible	Not Eligible	Not Eligible	25%
Over \$90,001	Not Eligible	Not Eligible	Not Eligible	Not Eligible	Not Eligible

For Applicants over 18 and under 65 Years of Age - include applicant's and applicant partner's tax assessments, married or common-law, if applicable.
(Effective November 2009)

Family ¹ Annual Net Income	REQUIRED CO-PAYMENT PERCENTAGE & (MAXIMUM CO-PAYMENT) OF WHEELCHAIR COST ²
Under \$21,000	No co-pay
\$21,001 to \$22,000	5%
\$22,001 to \$23,000	10 %
\$23, 001 to \$24,000	15 %
\$24,001 to \$25,000	20%
\$25,001 and over	Not Eligible

NOTES: 1 Family refers to persons who live in the same dwelling and are related by marriage or common law
2 Applicant must provide co-payment amount to the retail supplier before receiving the wheelchair