



Easter Seals Nova Scotia  
22 Fielding Ave. Dartmouth NS B3B 1E2  
[wheelchairs@easterseals.ns.ca](mailto: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 THERAPIST**

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](mailto: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	
<b>Base</b> Manual <input type="checkbox"/> Folding <input type="checkbox"/> Non-folding Power <input type="checkbox"/> Rear-wheel <input type="checkbox"/> Mid-wheel <input type="checkbox"/> Front-wheel <input type="checkbox"/> Power assist	Type:  Width:                                  Depth:                                  Height:
<b>Positioning Components</b> <input type="checkbox"/> Tilt <input type="checkbox"/> Manual <input type="checkbox"/> Power <input type="checkbox"/> Other: _____	Type: <input type="checkbox"/> Not Applicable
<b>Input Device</b>	Type: <input type="checkbox"/> Not Applicable Location:
<b>Critical Angles</b> Seat to Back: Foot rests:	
<b>Armrests</b>	<input type="checkbox"/> Not Applicable
<b>Footrests and Plates</b>	<input type="checkbox"/> Not Applicable
<b>Tie Downs</b>	<input type="checkbox"/> Not Applicable

Wheelchair User Name: \_\_\_\_\_ HCN: \_\_\_\_\_

<b>Cushion</b>	Type: _____ <input type="checkbox"/> Not Applicable Width: _____ Depth: _____
<b>Back</b>	Type: _____ <input type="checkbox"/> Not Applicable Width: _____ Height: _____
<b>Pelvic Support</b>	Type: _____ <input type="checkbox"/> Not Applicable
<b>Headrest</b>	Type: _____ <input type="checkbox"/> Not Applicable Mounting hardware: _____
<b>Additional Positional Supports</b>	_____ <input type="checkbox"/> Not Applicable
<b>Accessories</b>	_____ <input type="checkbox"/> 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.

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Therapist Signature: \_\_\_\_\_

Name printed: \_\_\_\_\_

Contact #: \_\_\_\_\_

CC: Health Records  
Care Coordinator  
Vendor