Manitoba
www.manitoba.ca/fs/dhsu

MEDICAL EQUIPMENT REQUEST AND JUSTIFICATION

RESET FORM

This request is in support of an individual enrolled in the following program(s):

- ☐ Employment and Income Assistance
- ☐ Manitoba Supports for Persons with Disabilities
- ☐ Children's disABILITY Services
- ☐ Community Living disABILITY Services

Family Services is authorized to collect personal information and personal health information under section 36(1)(b) of The Freedom of Information and Protection of Privacy Act ("FIPPA") and section 13(1) of The Personal Health Information Act ("PHIA") respectively, as the information is directly related to and necessary for the purposes of administering eligible supports provided by the programs identified at the top of this document and facilitating the procurement and delivery of medical supplies and equipment. We have limited the information we are collecting about you to the minimum amount necessary for these purposes. Your information is protected by the protection of privacy provisions of FIPPA and PHIA. We cannot use or disclose it for any other purpose, unless you consent or we are authorized or required to do so by FIPPA and PHIA. If you have any questions about your information, please contact the FIPPA Coordinator at (204) 945-2013 or 2nd floor 114 Garry Street, Winnipeg, MB R3C 4V4.

- **Section 1:** to be completed on behalf of the applicant (e.g. the "client").
- **Section 2:** to be completed only by Regulated Health Professional.
- **Section 3a:** to be completed on behalf of the applicant (e.g. the "client") by any Regulated Health Professional.
- **Section 3b**: to be completed on behalf of the client by an Occupational, Physical, Respiratory or Speech Language Therapist. Justification letters for specialized equipment requests must be included in or attached to this request form.

PROGRAM OBJECTIVE: To provide basic, cost effective medical equipment and devices to meet a medically essential need.

SECTION #1: CLIENT INFORMATION

CLIENT SURNAME	GIVEN NAME	MIDDLE INITIAL	BIRTHDATE (DD MM YY)	
ADDRESS:	TOWN/CITY	POSTAL CODE	TELEPHONE/CONTACT NUMBER	
DELIVERY ADDRESS (if different from above)	TOWN/CITY	POSTAL CODE	GENDER: ☐ M ☐ F	PHIN:
PARENT/GUARDIAN/AGENCY (if applicable)	CASE NUMBER (if applicable)		DATE OF REQUEST (DD MM YY)	
HEIGHT (ft/in) and WEIGHT (lbs): HEIGHT: WEIGHT:	ARE ANY OF THESE BENEFITS COVERED UNDER ANY OTHER PUBLIC OR PRIVATE HEALTH CARE PLAN (e.g. RHA, MPI, BLUE CROSS, WCB, FNIHB or OTHER) ☐ YES ☐ NO IF YES WHICH BENEFIT(S):			
DELIVERY INSTRUCTIONS (if applicable)				

SECTION #2: PRESCRIBER / REGULATED HEALTH PROFESSIONAL INFORMATION

SURNAME	GIVEN NAME		ORGANIZATION
ADDRESS	TOWN/CITY	POSTAL CODE	TELEPHONE/CONTACT NUMBER
FAX NUMBER	E-MAIL ADDRESS		SIGNATURE
IS THIS CLIENT PENDING HOSPITAL DISCHARGE? ☐ YES ☐ NO			DISCHARGE DATE:

SECTION #3a: STANDARD EQUIPMENT REQUEST (Available in MDA Catalogue)

DIAGNOSIS
DESCRIBE THE IMPACT OF THE CLIENTS MEDICAL CONDITION ON DAILY FUNCTIONING

CATALOGUE PRODUCTS (See the MDA Medical Products Catalogue if Applicable additional items can be attached on a separate sheet)

SAP #	QUANTITY	PRODUCT DESCRIPTION

SECTION #3b SPECIALIZED EQUIPMENT REQUEST (Please include justification letter/report to support the request as instructed below)

DIAGNOSIS

EXAMPLES OF RELEVANT INFORMATION TO JUSTIFY SPECIALIZED EQUIPMENT REQUESTS (i.e. lift systems, tracking, ramps, etc.)

ASSESSMENT FINDINGS:

- What precipitated the request?
- What are the outcomes/goals for use of requested equipment/device?
- Health information:
  - Relevant medical interventions? (include applicable medical reports)
  - Prognosis?

FUNCTIONAL/ ENVIRONMENT SUMMARY:

- If required, has a home assessment been completed?
- Functional status (e.g. mobility, transfers, ADL skills)
- Physical skills or limitations as it relates to the equipment requested (e.g. head control, ROM, vision, balance etc.)
- Cognitive skills as it relates to equipment requested (e.g. visual spatial skills, judgment etc).

ENVIRONMENT AND OTHER SUPPORTS:

- Indicate the type and status of present equipment and why it no longer meets the needs of the client.
- What was the funding source of the current equipment (if known).
- How is the need currently being met?

PRODUCT PARAMETERS:

- Identify possible equipment solutions (more than one possible solution?).
- Specify product parameters, and provide medical justification for each.

EQUIPMENT TRIALED:

- Indicate each piece of equipment/device trialed and outcome of trial
- Document reason for elimination of options not considered.

COMMUNICATION DEVICE (Children's disABILITY Services Clients Only):

- The adaptive and augmentive communication (AAC) device must be the child's primary mode of communication. Home computers do not fall within ACC devices category.
- Must demonstrate why the ACC is needed and how it will meet the child's needs.
- Is the ACC disability related and would not be required by a child of a similar age without a disability?

JUSTIFICATION:

- Identify the relationship between the client's medical needs and the equipment requested
- Provide justification for components of equipment especially if they are considered to be "up charges" (e.g. beyond "basic and essential")
- Indicate the expected targeted outcomes for the equipment requested.

PLEASE FORWARD COMPLETED REQUEST ELECTRONICALLY, E-MAIL , FAX OR MAIL TO:

Disability and Health Supports Unit – Provincial Services / 100 – 114 Garry Street, Winnipeg MB R3C 1G1

TELEPHONE INQUIRIES, PLEASE PHONE (204) 945-4393 or toll free 1-877-587-6224 or FAX (204) 945-1436 or E-MAIL

disandhealthsupports@gov.mb.ca

FOR OFFICE USE ONLY

CASE MANAGER'S NAME		REGIONAL OFFICE / COMMUNITY AREA
DATE COMPLETED	INFACT CLIENT IDENTIFIER	ASSESSMENT OFFICER / SERVICE ADVISOR INITIALS

This information is available in alternate formats upon request.
Ces renseignements sont offerts dans de multiples formats sur demande.

PRINT FORM

SUBMIT FORM