Criteria Screening Tool - Wheelchair Carrier

See procedure ‘Completing eligibility assessment screening tool’ for instructions on completing this screen

**Client name:** **Client/file number:**

**Client DOB:** **Client address:**

**Screen Completed by: Name:** **Position:**

**Screen Completed with:** q **Client** q **Other:**

 *(name and relationship to client)*

**Confirm diagnosis/relevant recent medical history:**

**Current Equipment Program equipment:**

**Current services received:**

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| --- |
| **1.** **Does the client live in a residential aged care facility or receive an Aged Care Package?** q Yes, refer to procedure q No, continue with screen |
| **2. Is the client a DVA Gold Card Holder or are they eligible for the equipment item through compensation payment or any other source?** q Yes If person is eligible for the item from DVA, compensation or other funding, screening assessment can be stopped at this point, person ineligible via the Equipment Program. q No |
| **3. Does the client currently have a wheelchair carrier/car hoist?** Check current equipment listed.  q Yes, if records show and client confirms that they have the same item owned by the Equipment Program, record issues with it/reason replacement is needed and stop screen as they will be eligible for replacement. q NoDetails of who owns it/issues with it:  |
| 1. **Does the client drive?** *If for carrier, consider client’s access to accessible vehicle/ability to use all controls of vehicle/whether modified vehicle is needed/available.*

 q Yes q No***If the client can drive*: Can the client transfer in/out of the car and complete the tasks that they need to do when they get to their destination?****For applications for roof mounted carriers: if the person is not the driver, they will be ineligible** |
| **5. How does the client currently mobilise? Does the client use any equipment or aids?** ***If person walks:* How far can the client walk?** Details: |
| **6. Does the client use a manual wheelchair? Is this used for all outdoor mobility?**Details of use/distances that person can propel/distances carer can propel client in manual w/chair: |
| **7. How does the client transfers in and out of car?** *Consider person’s ability to independently transfer in and out of vehicle and attach the wheelchair to the carrier.* Details: |
| **8. How does the client currently load/unload their wheelchair into the car?** *Consider techniques/positioning already trialed to load wheelchair into car.* |
| **9. What tasks would the client use a vehicle for if they had a wheelchair carrier?** |
| **10. Does the client have any help with transport from carers?** (family members or paid carers) *Consider relationship of any potential drivers and sustainability/appropriateness of them assisting the person with transport e.g. person’s spouse who does not work may be appropriate while a house mate or someone who works full time may not be appropriate to complete this role. Consider whether carer is managing/coping and carer’s health.* Details: |
| **11. How does the client currently get their shopping done / attend medical appointments?** Details: |
| **12. What other options has the client tried/considered?** *(E.g. home delivery of groceries, MoW, any council or community services available, taxis, access cabs, public transport).*Details of options and why unsuitable: |
| **13. How often would the client use a wheelchair carrier if they had one?** Details: |
| **14. Does the client own their own vehicle? Does it already have a tow bar (for tow bar mounted carrier)? Are they planning to keep this vehicle for the foreseeable future? If no tow-bar, are they willing to purchase this if they are eligible for a carrier?** |
| **15. Would you like to provide any more information about the client’s need for a wheelchair carrier?** |
| **16. Does the client give consent for the Equipment Program Delegate to talk to any other health professionals to provide any extra information if needed?** q Yes q NoDetails: |

|  |  |  |
| --- | --- | --- |
| 1 | For tow bar mounted wheelchair carrier:* Is essential to allow client to use vehicle? **AND**
* Non equipment options/other methods of loading w/chair are not able to be used? **AND**
* Client or carer is able to safely transfer into the vehicle once the wheelchair is stowed on the tow bar? **AND**
* Client has a tow bar or is willing to purchase one?
 | Y / N |
| 2 | For roof mounted wheelchair carrier:- The client is the driver of the vehicle? **AND**- The carrier is essential to allow the client to use the vehicle? **AND**- The vehicle is in good working order to allow installation of the carrier? **AND**- The client owns their own vehicle? **AND**- The client does not plan to sell the vehicle in the foreseeable future? | Y / N |
| 3 | For car hoist (person lifter):* Other transport options are not available to the client? **AND**
* The client owns their own vehicle? **AND**
* The client does not plan to sell the vehicle in the foreseeable future?
 | Y / N |
| 4 | The item is essential for vehicle use? | Y / N |
| 5 | The item will be used at least 3 – 4 times per week? | Y / N |

A **Yes** to 1,2 or 3 (all sections) **and** 4 and 5 is **likely** to make the person eligible for the item.

Signature of person completing the screening assessment

Print Name: Date completed

**To be completed by the Equipment Program Delegate:**

**Final outcome – Eligible? q Yes q No**

Signed by delegate: Date:

Delegate name: Delegate Position:

**q Outcome letter sent to client if not eligible**

Signed: Date: