

**Personal Wheelchair Budget Support plan**

Please fully complete section 1 of the support plan and have it with you at your assessment. Please complete the form with as much detail as possible, if needed speak to family, friends or other health professionals to ensure you supply as much information as possible.

**Section 1**

Name Date of birth

|  |
| --- |
| About me (what is important to you, your interests, hobbies etc.)- |

|  |
| --- |
| My health conditions and how they affect me- |

|  |
| --- |
| What I want to be able to achieve with my wheelchair- |

|  |
| --- |
| Who is important to me and how they support/assist me. These people could be your family, other health professionals, carers, teachers etc. Please include their contact details if needed.  |

Signed by PWB recipient

Name Date