Centre intégré de santé et de services sociaux de la Montérégie-Centre
Québec

APPLICATION FORM / INTERVENTION PLAN
TRANSPORTATION AND ACCOMMODATION PROGRAM
FOR PEOPLE WITH DISABILITIES – MONTÉRÉGIE (Center-East-West)

Québec health insurance number

☐ First request ☐ Revaluation ☐ Addition/Modification Date : _____ / _____ / _____
Year Month Day

1. IDENTIFICATION OF THE HANDICAPPED PERSON

Last name (at birth) : _____ First name : _____ ☐ W ☐ M

Date of birth : _____ / _____ / _____
Year Month Day

Address : _____ App. _____

City : _____ Postal code : _____

Phone : ( ) _____ ( ) _____
First number Second number

Written correspondence : French ☐ English ☐

Email correspondence Yes ☐ No ☐ Email address : _____

2. IDENDIFICATION OF THE HANDICAPPED PERSON'S REPRESENTATIVE

Last name : _____ First name : _____

Relationship to the person for whom the request is made :

☐ Father-Mother ☐ Tutor ☐ Spouse ☐ Curator ☐ Other (specify) _____

Address (if different) : _____ _____ _____
No Street App.

_____ Québec _____
City Province Postal code

Phone : ( ) _____ ( ) _____
First number Second number

3. IDENTIFICATION OF THE CREDITOR IN THE NAME OF WICH PAYMENTS WILL BE MADE

☐ Handicapped person ☐ Representative ☐ Transport company

☐ Other →Name (if different than #1) _____

Address : _____

_____

4. INDICATE THE SOURCE OF INCOME

(If the child is not 18 years of age, indicate the source of family income)

☐ Employment (or spouse's job)
☐ CNESST
☐ Old age pension and income supplement
☐ Personal insurance benefit
☐ RRQ
☐ Welfare assistance
☐ SAAQ
☐ Other, (specify) : _____

5. IDENTIFICATION OF YOUR DIAGNOSIS

Please attach to this request a medical certificate or a report from a recognized professional of the Health and Social services network certifying your diagnosis and your disability.

ADDITIONNAL INFORMATION* (to be completed only if this information does not appear in the report provided for this request):

Name of your disability : _____

Describe briefly your handicap(s) physical, intellectual or other limitations :

_____

_____

Cause(s) of your handicap(s)

☐ Since birth

☐ Cause by illness Date : _____ / _____ / _____ (Year / Month / Day)

☐ Cause by a work accident Date : _____ / _____ / _____ (Year / Month / Day)

☐ Cause by a car accident Date : _____ / _____ / _____ (Year / Month / Day)

☐ Other Date : _____ / _____ / _____ (Year / Month / Day)

Specify : _____

Technical assistance :

Do you have to use technical assistance (prosthesis, ortosis or any other ways of compensating for your limitation(s)?

If yes, which ones?

_____

_____

_____

*The professional health and social services staff can write the information of the medical certificate in this section if they do not attach a report to this request as long as they affix their signature on page 3.

6. IDENTIFICATION OF SERVICES TO BE PROVIDED (to be completed by the professionnal of the social or medical sector)

SERVICE TO BE PROVIDED

Audiology	☐	Hemodialysis	☐
Specialized education	☐	Speach therapy	☐
Occupational therapy	☐	Physiotherapy	☐
Other (specify) :	☐		

Briefly describe the service : _____

Service point name : _____

Address : _____

Number of visit : _____ /Week **Or** _____ /Month **Or** _____ /Year

Expected period : From _____ / _____ / _____ (Year / Month / Day) To _____ / _____ / _____ (Year / Month / Day)

Means of transportation

☐ Personal vehicle ☐ Adapted transportation ☐ Public transport

☐ Volunteer transportation ☐ Taxi ☐ Other (specify) : _____

Lodging _____ Night Attendant ☐ Yes ☐ No

☐ Hotel ☐ Family/friend

Meals

Disabled person	Breakfast	☐	Lunch	☐	Supper ☐
Attendant	Breakfast	☐	Lunch	☐	Supper ☐

6. IDENTIFICATION OF SERVICES TO BE PROVIDED (to be completed by the professionnal of social or medical sector)

SERVICE TO BE PROVIDED

Audiology ☐ Hemodialysis ☐
Specialized education ☐ Speach therapy ☐
Occupational therapy ☐ Physiotherapy ☐
Other (specify) : ☐ _____

Briefly describe the service : _____
Service point name : _____
Address : _____

Number of visit _____ /Week **Or** _____ /Month **Or** _____ /Year
Expected period : From ___/___/___ To ___/___/___
Year Month Day Year Month Day

Means of tranportation

☐ Personal vehicle ☐ Adapted transportation ☐ Public transport
☐ Volunteer transportation ☐ Taxi ☐ Other (specify) : _____

Lodging _____ Night Attendant ☐ Yes ☐ No
☐ Hotel ☐ Family/friend

Meals

Disabled person Breakfast ☐ Lunch ☐ Supper ☐
Attendant Breakfast ☐ Lunch ☐ Supper ☐

6. IDENTIFICATION OF SERVICES TO BE PROVIDED (to be completed by the professionnal of the social of medical sector)

SERVICE TO BE PROVIDED

Audiology ☐ Hemodialysis ☐
Specialized education ☐ Speach therapy ☐
Occupational therapy ☐ Physiotherapy ☐
Other (specify) : ☐ _____

Briefly describe the service : _____
Service point name : _____
Address : _____

Number of visit : _____ /Week **Or** _____ /Month **Or** _____ /Year
Période prévue : From ___/___/___ To ___/___/___
Year Month Day Year Month Day

Means of transportation

☐ Personal vehicle ☐ Adapted transportation ☐ Public transport
☐ Volunteer transportation ☐ Taxi ☐ Other, specify _____

Lodging _____ Night Attendant ☐ Yes ☐ No
☐ Hotel ☐ Parents/amis

Meals

Disabled person Breakfast ☐ Lunch ☐ Supper ☐
Attendant Breakfast ☐ Lunch ☐ Supper ☐

7. IDENTIFICATION OF THE MEDICAL OR SOCIAL PROFESSIONNAL

Last name _____ Fist name _____ Function _____

Service point name : _____

Address : _____

Phone ( ) _____ Date ___/___/___
Year Month Day

Signature of professional : _____

8. COMMITMENT WITH THE CONDITIONS OF THE PROGRAM

I have read the conditions of the Transportation and accommodation program for people with disabilities and I undertake to respect them. I authorize the CISSS de la Montérégie (Center-East-West) to proceed by direct deposit for the payment of travel claims under the Transportation and accommodation program for people with disabilities and I enclose a specimen check bearing the word «VOID».

Signature of the user (14 years old and over) or his legal representative _____ Date : ____ / ____ / ____
Year Month Day

Name of doctor or professional _____ Title : _____

Signature of doctor or professional _____ Date : ____ / ____ / ____
Year Month Day

Office address (obligatory) _____ Phone : ( )

SEND THIS COMPLETED AND SIGNED FORM TO THE TRANSPORTATION AND ACCOMMODATION PROGRAM :

- by email : transport.csssccclm16@ssss.gouv.qc.ca
- by fax : (450) 463-6072
- by mail : 3120, Taschereau blvd
  Greenfield Park (Québec) J4V 2H1