

FINANCIAL YEAR 2021-2022

QUEBEC HEALTH INSURANCE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--

IDENTIFICATION OF THE PERSON LIVING WITH DISABILITIES:

Last name: _____

Fist name: _____

Circle the days during which the person went to your care center to receive the expected service

		Nb. visits	Nb. meals
	APRIL 2021 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	_____	_____
1	MAY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
	JUNE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	_____	_____
	REQUIRED SUPPORTING DOCUMENTS FOR JULY 10TH 2021		
	JULY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
2	AUGUST 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
	SEPTEMBER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	_____	_____
	REQUIRED SUPPORTING DOCUMENTS FOR OCTOBER 10TH 2021		
	OCTOBER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
3	NOVEMBER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	_____	_____
	DECEMBER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
	REQUIRED SUPPORTING DOCUMENTS FOR JANUARY 10TH 2022		
	JANUARY 2022 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
4	FEBRUARY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29	_____	_____
	MARCH 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	_____	_____
	REQUIRED SUPPORTING DOCUMENTS FOR APRIL 10TH 2022		

TOTAL OF VISITS:
 TOTAL OF MEALS:
 TOTAL PARKING:

MEANS OF TRANSPORTATION:

- PERSONAL VEHICLE ADAPTED TRANSPORTATION* PUBLIC TRANSPORT*
 VOLUNTEER TRANSPORTATION* TAXI* OTHER: _____

****Attach supporting documents relating to such transport****

IDENTIFICATION OF THE CARE CENTER: _____

ADDRESS 1: _____ ADDRESS 2: _____

NEEDS AND SERVICES RECEIVED: _____

Signature of the healthcare manager or the therapist who gave the health service

20____/____/____
Year Month Day

RETURN ADDRESS: Programme Transport et hébergement des personnes handicapées Montérégie
3120, Taschereau blvd
Greenfield Park (Québec) J4V 2H1

Phone number: 450-928-6777, ext. 13553
Fax: (450) 463-6072
Email: transport.cssscclm16@ssss.gouv.qc.ca