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 ☐Communication to handicapped person's representative

Email correspondence 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 ☐

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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 ☐

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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 : ______________________

Email address : ______________________

8. COMMITMENT WITH THE CONDITIONS OF THE PROGRAM

I have read the conditions of the Transportation and accommodation program for people with disabilities-Monteregie and I undertake to respect them. I authorize the CISSS de la Montérégie-Centre (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.cssscclm16@ssss.gouv.qc.ca
- by fax : (450) 463-6072
- by mail : 3120, Taschereau blvd
  Greenfield Park (Québec) J4V 2H1