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

TRANSPORTATION AND ACCOMMODATION PROGRAM
FOR PEOPLE WITH DISABILITIES - MONTÉRÉGIE

Calendar of visits made for authorized transportation

FINANCIAL YEAR 2024-2025

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 2024 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 2024		
	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 2024		
	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 2025		
	JANUARY 2025 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 2025		

TOTAL OF VISITS: ☐ **TOTAL OF MEALS:** Disabled person ☐ Attendant ☐ **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: _____

_____ 20____/____/____
Signature of the healthcare manager or the therapist who gave the health service — 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