Centre intégré de santé et de services sociaux du Bas-Saint-Laurent
Québec

Claim Form (FINANCIAL ASSISTANCE FOR USERS PROGRAM)

Please ensure that **SECTION 1, SECTION 2** (if applicable) and **SECTION 3** of this form are duly completed, and that the relevant documents are attached to this form. Please keep all official receipts for your tax return as we do not return them. Please note that incomplete forms will be returned.

Please submit this form within 90 **days of your travelling** to the following address :

CISSS du Bas-Saint-Laurent
Service de la comptabilité
800, avenue du Sanatorium
Mont-Joli (Québec) G5H 3L6

SECTION 1 USER (Please complete all fields)

Last Name : _____ First Name : _____

Adress : _____
Civic no Street

_____
City Province Postal Code

Phone Number : Home : ( ) _____ Work : ( ) _____

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

Health Insurance Card No : _____
(RAMQ Card)

Email address : _____

Mode of transportation used : Departing : _____ Returning : _____

Transportation claim : Date of departure : _____ Date of return : _____

Have you previously sent in a claim through this program? ☐ Oui ☐ Non

Do you receive benefits from a financial assistance program provided by :

- Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)? ☐ Oui ☐ Non
- Ministère du Travail, de l'Emploi et de la Solidarité sociale (Welfare)? ☐ Oui ☐ Non
- Transport hébergement personnes handicapées (refer to your CLSC)? ☐ Oui ☐ Non
- Société de l'assurance automobile du Québec (SAAQ) ? ☐ Oui ☐ Non
- Others _____ ☐ Oui ☐ Non

In order to determine the paying agent, do you authorize us to make the necessary verifications with the organizations involved? ☐ Oui ☐ Non

<u>If this is a first consultation, please attach a photocopy of your medical prescription (prescription from a physician from the Bas-Saint-Laurent) and void cheque to this form.</u>

Signature of the user : _____ Date : _____

SECTION 2 PERSON ACCOMPANYING THE USER

Last name : _____ First Name : _____

Adress : _____
Civic no Street

_____
City Province Postal Code

Phone Number : Home : ( ) _____ Work : ( ) _____

SECTION 3 INSTITUTION PROVIDING THE SERVICES REQUIRED

(STAMPA)

Name of the destination institution :

_____

Adress : _____
Civic no Street

_____
City Province Postal Code

Number phone : ( ) _____

Name of attending physician : _____ Permis no : _____

Specialty : _____

Description of the treatment : _____

Date of the appointment : ___/___/___ Est-ce un suivi? _____
Year Month Day

Hospitalization date : From : ___/___/___ To : ___/___/___
Year Month Day Year Month Day

Accompanying person required by the doctor (for the return) : ☐ Oui ☐ Non

Signature of attending physician or person authorized : _____ Date : _____

SECTION 4 CISSS du Bas-Saint-Laurent (Section reserved for the Accounting Service)

Name of the installation from the Bas-Saint-Laurent region:

_____

Date form received: ___/___/___
Year Month Day

This request meets the eligibility criteria : ☐Oui ☐Non
The relevant documents have been provided : ☐ Oui ☐ Non

NOTES

This request is :

☐ Accepted	☐ Refused
Amount granted : _____	Reasons for refusal : _____
Details, if necessary : _____	_____
Supplier's No : _____	_____

Signature of the responsible : _____ Date : _____