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

Claim Form
(FINANCIAL ASSISTANCE PROGRAM FOR USERS)

Please ensure that **SECTION 1, 2** (if applicable) **3 and 4** of this form are completed, and that supporting documents are attached to this form. Keep your original receipts for your annual tax return. Those you submit with your claim won't be sent back to you. Incomplete forms will be returned to you.

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

CISSS du Bas-Saint-Laurent
Service de la comptabilité
800, avenue du Sanatorium
Mont-Joli (Québec) G5H 3L6
aidefinanciere200km.cisssbsl@ssss.gouv.qc.ca

SECTION 1 User *(please complete all fields)*

Last Name : _____ First Name : _____

Adress : _____
Civic No. Street

_____
City Province Postal Code

Telephone Number : Home : ( ) Work : ( )

Date of Birth : ____ / ____ / ____ Health Insurance Card No. : (RAMQ Card)
Year Month Day

Email :

Mode of transportation : Initial trip : Return trip :

Travel dates : Departure date : Return date :

Have you already submitted a claim under this program? ☐ Yes ☐ No

Do you receive financial assistance from :

- Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)? ☐ Yes ☐ No
- Ministère du Travail, de l'Emploi et de la Solidarité sociale (social assistance)? ☐ Yes ☐ No
- Travel Expense Program for people with disabilities (refer to your CLSC)? ☐ Yes ☐ No
- Société de l'assurance automobile du Québec (SAAQ)? ☐ Yes ☐ No
- Other : ☐ Yes ☐ No

Do you authorize us to check with the appropriate organizations to identify the paying agent? ☐ Yes ☐ No

If this is your first claim, please attach to this form a photocopy of your medical prescription from the Bas-Saint-Laurent physician (or have them complete SECTION 3 of this form) and a void cheque.

User's signature :_____ Date : _____

SECTION 2 Accompanying person *(if applicable)*

Last Name : _____ First Name : _____

Address : _____
Civic No. Street

_____
City Province Postal Code

Telephone : Home : ( ) _____ Work : ( ) _____

SECTION 3 Bas-Saint-Laurent physician who prescribed the trip
(or attach a copy of the doctor's prescription)

Reason for referral (specialty) : _____

Doctor's name (print) : _____

Licence No. : _____

Is this the closest institution offering the service? ☐ Yes ☐ No

If not, specify why: _____

Do you have to be accompanied by a family member or an attendant? If so, physician's initials : _____

Signature of Bas-Saint-Laurent physician or autorized person : _____ Date : _____

SECTION 4 Institution that will be providing the required services

(STAMPA)

Institution Name : _____

Adress : _____
Civic No. Street

_____
City Province Postal Code

Name of out-of-region physician : Licence No. : _____

Specialty : _____

Treatment received : _____

Appointment date : _____ / _____ / _____ Is this a follow-up? ☐ Yes ☐ No
Year Month Day

Date of hospitalization: From : _____ / _____ / _____ To : _____ / _____ / _____
Year Month Day Year Month Day

Accompanying person requested by physician : ☐ Yes ☐ No

Service covered by the RAMQ : ☐ Yes ☐ No

Signature of out-of-region physician or authorized person : _____ Date : _____

SECTION 5 **CISSS du Bas-Saint-Laurent** *(section reserved for Accounting Department)*

Reception date: ____ / __ / ____
Year Month Day

This request is :

☐ Accepted	☐ Refused
Amount : _____	Reason for refusal (if applicable) : _____
Quantity : _____	_____
Budget code : _____	_____

Signature of the accountant : _____ Date : _____