Centre intégré
de santé
et de services sociaux
de la Côte-Nord

Québec

ANNEX 5

REGISTRATION FORM

Service request

(to be filled out by the user or their representative)

Centre intégré
de santé
et de services sociaux
de la Côte-Nord

Québec

TRANSPORTATION AND HOUSING PROGRAM
FOR PEOPLE WITH DISABILITIES

INFORMATION

1. All sections of the registration form **must be filled out** by the **person themselves, their representative, or an intervenor of the health and social services network.**

2. Ask **a health professional to fill out** one of the following **annexes**, according to your condition:

Annex 5-A	Diagnostic report, motor disability
Annex 5-B	Diagnostic report, organic disability
Annex 5-C	Diagnostic report, psyche disability
Annex 5-D	Diagnostic report, visual impairment
Annex 5-E	Diagnostic report, hearing impairment
Annex 5-F	Diagnostic report, speech and language disability
Annex 5-G	Diagnostic report, intellectual disability

3. If you have to travel by plane and/or with an escort, make sure the "transportation mode" section of the diagnostic report is duly completed by the health professional.

The travel by plane and the expenses for an escort are reimbursed if the safety or the health condition of the person is at stake.

- **For the clientele with no road access, the travel by plane is systematically accepted.**
- **The escort is accepted when the person under 18 years of age or over 75 years of age.**

4. Send the completed registration form and diagnostic report to the following address:

Programme transport et hébergement pour les personnes handicapées
Centre intégré de santé et de services sociaux de la Côte-Nord
835, boul. Jolliet
Baie-Comeau (Québec) G5C 1P5

Centre intégré
de santé
et de services sociaux
de la Côte-Nord
Québec

TRANSPORTATION AND HOUSING PROGRAM
FOR PEOPLE WITH DISABILITIES

835, boul. Jolliet Baie-Comeau (Québec) G5C 1P5
Tel.: (418) 589-9845, ext. 252223 – Fax: (418) 589-8574
Toll free: 1800-463-5142

SERVICE REQUEST

1. Client identification

LAST NAME:	FIRST NAME:	
DATE OF BIRTH:	H.I.N.:	SEX: F ☐ M ☐
TELEPHONE:	CELL PHONE:	TEL. NO. (work):
ADDRESS:		
CITY:	POSTAL CODE:	
EMAIL:		
CURRENT SITUATION: ☐ Nat. fam. ☐ F.T.R. ☐ Com. res. ☐ Inter. res. ☐ Other:		
SPOUSE'S NAME:		
LEGAL REPRESENTATIVE: ☐ Father ☐ Mother ☐ Both ☐ Curator ☐ Other:		
FATHER'S NAME:	MOTHER'S NAME:	
ADDRESS (if different from the user's):		

MOTIVES FOR THE REQUEST

ENCLOSE A SUMMARY OF THE FILE OR ANY RELEVANT DOCUMENT FOR THE PROCESSING OF THE REQUEST:
DIAGNOSIS:
SAAQ FILE NO.: _____ **CNESST:** _____ **OTHER:** _____

REFERENT

PERSON'S NAME AND PROFESSION:	ESTABLISHMENT/ORGANIZATION:
ADDRESS:	TELEPHONE: EXTENSION:

SIGNATURE OF THE USER OR THEIR LEGAL REPRESENTATIVE (please specify the type of relationship)

Signature: _____ Date: _____

2. Transportation identification

This section allows you to identify your transportation needs.

A. Reasons for transportation

Diagnostic services, which ones: (Examples: follow-up of the evolution of the condition, post-surgery follow-up, adjustment to the medication)

_____

_____

Adjustment and rehabilitation services, which ones: (Examples: physiotherapy, occupational therapy, adjustment of braces, prostheses)

_____

_____

Medical treatments, which ones: (Examples: dialysis, surgery, or any other treatment recognized by the R.A.M.Q.)

_____

_____

B. Transportation mode used:

☐ Bus
☐ Automobile
☐ Airplane (you must provide a medical referral, see the "transportation mode" section of the diagnostic report)*

☐ No escort
☐ With an escort (you must provide a medical referral, see the "transportation mode" section of the diagnostic report)**

C. Establishments where the services are provided

1. Establishment: _____
   Place: _____
   Required services: _____
   _____

2. Establishment: _____
   Place: _____
   Required services: _____
   _____

3. Establishment: _____
   Place: _____
   Required services: _____
   _____

4. Establishment: _____
   Place: _____
   Required services: _____
   _____

*** Note:** **For the clientele with no road access, the travel by plane is systematically accepted.**
**** Note:** **The escort is accepted when the person under 18 years of age or over 75 years of age.**

3. Identification of the diagnosis

A. Diagnosis

Write the diagnosis or diagnoses concerning you. Enclose the medical assessment for your diagnosis or use the appropriate annex.

1. _____

2. _____

3. _____

4. _____

B. Cause

Tick a box to indicate the cause and the date of onset of your diagnoses.

Diagnosis 1:		**Diagnosis 2:**	
☐ at birth		☐ at birth	
☐ due to a disease, which one:	Date: _____	☐ due to a disease, which one:	Date: _____
☐ work accident	Date:	☐ work accident	Date:
☐ traffic accident	Date:	☐ traffic accident	Date:
☐ other, specify:	Date: _____	☐ other, specify:	Date: _____

Diagnosis 3:		**Diagnosis 4:**	
☐ at birth		☐ at birth	
☐ due to a disease, which one:	Date: _____	☐ due to a disease, which one:	Date: _____
☐ work accident	Date:	☐ work accident	Date:
☐ traffic accident	Date:	☐ traffic accident	Date:
☐ other, specify:	Date: _____	☐ other, specify:	Date: _____

4.1 Identification of functional limitations

A. Teenager and adult (If you are aged 14 and over, you must completed this section.)

Here is a list of activities of daily living typically carried out by a person aged 14 and over. For each action, tick the answer that best describes the way you can usually carry it out according to your current condition.

Communication	Adequate	Problem	Types of compensation or explanations
Seeing			
Hearing			
Speaking			

ADL* / AVD* / Mobility	N/A*	Capable alone		With help		Incapable
		With difficulty	Without difficulty	From someone	technical	
1. Eating						
2. Personal hygiene						
3. Dressing/undressing						
4. Installing a brace/prosthesis						
5. Using the toilet						
6. Getting up / lying down / transfers						
7. Stretching, crouching						
8. Moving around						
9. Using stairs						
10. Using transportations						
11. Keeping the house						
12. Preparing meals						
13. Shopping						
14. Doing the laundry						
15. Using the telephone						

Mental functions	Adequate	Problem	Explanations
1. Memory			
2. Orientation			
3. Understanding			
4. Judgement			

Special care / Comments:

N/A: Not applicable
ADL: Activities of daily living
HLA: Home living activities

4.1 Identification of functional limitations

B. Child (If the person for whom you make the request is aged 13 and under, you must complete this section.)

Here is a list of activities of daily living typically carried out by a person aged 13 and under. For each action, tick the answer that best describes the way they can usually carry it out according to their current condition.

Communication	Adequate	Problem	Types of compensation or explanations
Seeing			
Hearing			
Speaking			

ADL* / Mobility	N/A*	Capable alone		With help		Incapable
		With difficulty	Without difficulty	From someone	technical	
1. Rolling from the back to the stomach and vice-versa						
2. Sitting						
3. Crawling on the stomach						
4. Moving around on all fours						
5. Walking						
6. Taking objects						
7. Manipulating toys						
8. Scribbling, drawing						
9. Eating						
10. Dressing/undressing						
11. Getting up / lying down						
12. Using stairs						
13. Reading/writing						
14. Using the toilet						

Special care / Comment: _____

*** ADL: Activities of daily living**
*** N/A: not applicable**

5. Technical aids

Do you use the following technical aids on a regular basis?

- ☐ None (go to section 6)
- ☐ Visual aids, specify: _____
- ☐ Hearing aids, specify: _____
- ☐ Walking aids (e.g. cane, walker, etc.), specify: _____
- ☐ Brace/prosthesis, specify: _____
- ☐ Motorized wheelchair:
- ☐ Manual wheelchair:
- ☐ Other type of chair, specify: _____
- ☐ Breathing device: number of hours used per day: _____

_____

- ☐ Hemodialysis machine: number of hours used per day: _____

_____

- ☐ Other, specify: _____

_____

6. Declaration of income

Where does your income come from?
(do not write the amount)

- ☐ Social solidarity (social assistance)*****
- ☐ Commission de la santé et de la sécurité du travail (CNESST)*****
- ☐ Société d'assurance automobile du Québec (SAAQ)*****
- ☐ Régie des rentes du Québec (RRQ)
- ☐ Old Age Security pension
- ☐ Employment
- ☐ Employment insurance
- ☐ Personal insurance
- ☐ Other, specify: _____

_____

*** Note:** In order to make it easier to process your request with the ministère de la Solidarité Sociale, the CNESST and the SAAQ, please write the name of the agent in charge of your file and your file number.

_____ _____

Name of the agent File number

7. Commitment

I, undersigned, _____ living
LAST NAME – FIRST NAME

at _____
ADDRESS

Declare that, to be best of my knowledge, the information provided is correct and complete.

I agree to inform those in charge of the transportation and housing program, as soon as possible, about any changes in my situation (or in the situation of _____) that may make the information I provided for the study of this request inaccurate.

8. Authorization

I authorize the members of the Registration Committee to contact the referent person, my attending physician, or any other rehabilitation professional involved in my file (occupational therapist, physiotherapist, speech therapist, social intervenor) if further details are required to process my request.

☐ **YES** ☐ **NO**

_____ _____
Signature of the person (or their representative) Date

This authorization is valid for a period of needs in Program transport and housing.