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

TRAVEL ALLOWANCE FORM AND USER TRAVEL ROAD MAP

File #: _____ RAMQ #: _____

Family name and name: _____

Full address: _____

Telephone: _____ Date of birth: _____

SPECIFY FACILITY								
Lower North Shore 7404700	Upper North Shore 7404369	Port-Menier 7404501	Hématite 7404401	Manicouagan 7404379	Minganie 7404500	Port-Cartier 7404600	Schefferville 7404400	Sept-Îles 7404800

1. SECTION FOR ATTENDING PHYSICIAN

Specialty: _____ **Name of physician**: _____

Treating facility: _____ **Reason for consultation**: _____

I certify that the required services are not available in the region: Yes ☐ No ☐

Eligibility criteria related to the request for an escort*:

1. ☐ **Minor (child under the age of 18 years)**
2. ☐ **Patient under a protection plan (tutorship or curatorship)**
3. ☐ **Patient with a serious and unstable mental condition or proven and significant dementia or specific mental retardation**
4. ☐ **Patient with a limited physical capacity requiring the constant help of a person**
5. ☐ **Patient with severe hearing loss that is not compensated, with a severe language disorder (mute, aphasia)**
6. ☐ **Situation where normal supervision provided for travelling may not be sufficient to ensure the safety of the patient and others**
7. ☐ **Visual disorder (blind or visually impaired) that is not compensated and requiring the assistance of a person to travel**
8. ☐ **Person accompanying a mother for childbirth**

* In the case whereby the patient does not meet the above criteria but presents serious aspects of vulnerability in their biopsychosocial health, the Orientation Committee may recommend an escort.

Escort: Yes ☐ No ☐

Paying agency: CNESST ☐ SAAQ ☐ Other ☐

User referred to prioritized access to specialized services (APSS) ☐ _____

Name of physician:: _____

_____ _____ _____

Signature of physician **Licence number** **Date**

2. AUTHORIZATION FROM CISSS DE LA CÔTE-NORD

Date of appointment: _____

Authorized city: _____

Purchase order #: _____

Number of kilometres (return trip) _____

Number of nights: _____

Escort: ☐ _____

Airplane travel:	☐ (6615)	
Taxi, bus, ferry, train:	☐ (6617)	
Personal automobile:	☐ (6623)	
Lodging and meals:	☐ (6625)	
Return trip – Remote areas:	☐ (6633)	
Lodging and meals (escort):	☐ (6627)	
Return trip – Remote areas (escort)**:**	☐ (6635)	
Airplane, taxi, bus, ferry, train (escort)**:**	☐ (6621)	
Financial assistance - Pregnant women:	☐ (6631)	
Total :		
Supplier #:		

☐ **ACCEPTED** ☐ **REFUSED**

_____ _____

Signature **Date**

This section must be completed by the Finance department

3. CONFIRMATION OF RECEIVED CARE

Signature of physician: _____

Licence #: _____ **Date:** _____

Hospitalization: Yes ☐ No ☐

Stay – From: _____ to _____

Self-inking stamp

4. CONFIRMATION OF RECEIVED CARE

YOUR CLAIM MUST BE RECEIVED WITHIN THIRTY (30) DAYS OF YOUR RETURN HOME.

PLEASE REMEMBER TO ATTACH YOUR SUPPORTING DOCUMENTS (SEE OVERLEAF).

Amount payable to: _____

_____ _____

Signature of user or escort **Date**

Please keep a copy of your claim form as no other reimbursement document or summary will be sent to you for income tax purposes

TRAVEL ALLOWANCE FORM

ROAD MAP

Your physician has referred you to a specialist?

A financial assistance program is available. To receive more information, ask your physician or go to the reception desk of your local facility part of the Centre intégré de santé et de services sociaux de la Côte-Nord.

Send your form to:

Demande d'allocation de transport des usagers (User travel allowance application)
Centre multiservices de santé et de services sociaux de la Minganie
Centre intégré de santé et de services sociaux de la Côte-Nord
1035, promenade des Anciens
Havre-Saint-Pierre (Québec) G0G 1P0

CRITERIA:

- Provide the signature of the attending physician or attach a copy of the request for a consultation.
- The section intended for the attending physician does not need to be filled out for medical follow-ups.
- The specialty is not available at the facilities of the CISSS de la Côte-Nord.
- Get your form authorized **BEFORE you leave**; a delay of 48 hours is required.
- Provide the signature of the consulting physician.

THE TRAVEL ALLOWANCE FORM IS AVAILABLE AT THE FACILITIES OF THE CISSS DE LA CÔTE-NORD

If you have not received your payment within six weeks, please contact the Financial resources department at **418-538-2212, ext. 542471.**

FINANCIAL ASSISTANCE FOR TRAVELLING DISTANCES OVER 200 KM

REIMBURSEMENT			
TRAVELLING EXPENSES	Personal automobile	Côte-Nord	$0.13/km, based on current ministry policy
		Remote areas*	$0.25/km
	Public transit (bus, ferry, train.)	Price of ticket reimbursed	
	Airplane (Remote areas)	Best price reimbursed (travel agency fees assumed by user))	
LODGING	User	Côte-Nord	$75/night – $44/night (relative or friend)
		Remote areas (Airplane only)	$75 return trip and $75/night $44 /night (relative or friend)
	Escort (requested by the attending physician and based on escort eligibility criteria)	Côte-Nord	$20/night
		Remote areas (Airplane only)	$20 return trip and $20/night
PARTICULAR CASES	Radio-oncology and transplants/grafts	$0.13/km or $0.25/km in remote areas	Reimbursement of daily lodging expenses, including meals charged by a hotel recognized by the Ministry **or** $150/week of treatment **Escort**: Reimbursement of hotel expenses **or** $20/week of treatment

- Supporting documents are required for the reimbursement of public transit and lodging expenses that are added to what was previously authorized.
- The number of kilometres reimbursed is the distance of the return trip from the facility where the user usually receives basic care and services OR the user's home to the facility offering the required services, minus the 200 km deductible. **The deductible does not apply to users in remote areas***.

* The user lives on Anticosti Island, between Kégaska and Blanc-Sablon, in Schefferville, Fermont or Kawawachikamach.

DIRECT DEPOSIT

Direct deposit authorization form

I, _____, authorize the CISSS de la Côte-Nord to deposit, in my bank account, the amounts related to my travelling expenses for care outside the region.

Name of account holder: _____

Transit #: _____ **Branch #:** _____ **Account #:** _____

E-mail address (if possible): _____

Signature of user: _____

***** ATTACH A SPECIMEN CHEQUE *****