

TRAVEL ASSISTANCE PROGRAM FOR USERS

Who is the program for?

The financial assistance program is for users of the Abitibi-Témiscamingue health and social services network who must travel outside the region, at the request of their physician, to receive health care and social services **not available** in Abitibi-Témiscamingue.

This program stems from the Politique de déplacement des usagers du réseau de la santé et des services sociaux du Québec (policy on travelling expenses for users of Québec's health and social services network). **It offers financial assistance to users, but does not reimburse all travelling and accommodation expenses.**

Eligibility criteria

To be eligible, the user must:

- be a Québec resident;
- have received a medical prescription from a physician in Abitibi-Témiscamingue for health or social services not available in the region and/or within the required timeframe;
- travel to a Québec health and social services institution more than 200 km away from the institution in Abitibi-Témiscamingue where they usually receive their basic care and services;
- travel to an institution that can provide the required care and services and is **nearest** to the institution they usually visit;
- travel for care and services **covered** by the Régie de l'assurance maladie du Québec (RAMQ).

Before travelling to your appointment, you can consult the website of the CISSS de l'Abitibi-Témiscamingue for information about the form to be completed to request a reimbursement.

The user must present to the institution in Abitibi-Témiscamingue all of the following supporting documents:

- The claim form for travelling expenses appended to this brochure. All sections of the form must be completed:
 - » Section 1: to be completed by the user
 - » Section 2: travel justification to be completed by the physician referring the user outside the region
 - » Section 3: confirmation of the appointment to be completed by the consulting physician outside the region
- Bus, accommodation and meal receipts

Your claim as well as all supporting documents must be submitted within a **maximum of 90 days** after the user's return. No reimbursement will be paid once this timeframe has elapsed.

****The user should keep a copy of this form once it has been completed and a copy of their receipts, before depositing them in the box reserved for this purpose.**

Travel expenses

Personal vehicle

For travel, the first 100 kilometres of an outward trip or returning trip (200 kilometres for a roundtrip) are paid for by the user. An allowance of \$0.22 per additional kilometre travelled is allocated by the health and social services institution. The distance travelled is calculated as of departure from the hospital in the user's city of residence. The financial assistance for **cancer cases** is different. The accompanying person is only reimbursed for travel with the user.

Bus

The user is reimbursed for the cost of a bus ticket at the regular rate, whether travelling one way or roundtrip. The cost of the ticket for the accompanying person is also reimbursed if the user is under 18 years of age or if the physician has specified on the claim form that the user must be accompanied due to their condition.

You must present the bus ticket receipt for you and the person accompanying you, if applicable.

Plane

If the user is travelling by plane, the cost of the plane ticket is not reimbursed by the institution, even with a medical prescription. An allowance equivalent to the amount the user would have received if they had used their personal vehicle will be allocated. No reimbursement is granted for a person accompanying the user by plane.

Meal and accommodation expenses

An allowance of \$120.43 per night is allocated to the user for accommodation expenses in order to receive care and services outside the region for a maximum of 2 nights (\$240.86). This amount includes the accompanying person's accommodation when required by the physician's medical prescription.

A daily subsistence allowance of \$51.57 is allocated to the accompanying person whose presence is required by the physician, up to a maximum of 2 days (\$103.14).

No additional allowance is allocated if the stay exceeds 2 nights.

You must present your accommodation and meal receipts.

Special terms and conditions for financial assistance:

For users who are undergoing radiation therapy or any other cancer-related treatment, a transplant or a graft, only accommodation in a hotel for cancer patients or transplant patients is covered in full. If another form of accommodation is chosen, the terms and conditions related to elective travel apply.

Once the form has been completed, send it by email or take it to the hospital in your area. Find out where the boxes for depositing your documents are located. We highly recommend that you append a specimen cheque to your application form to avoid any delay.

ACCOMPANYING PERSON

The physician can request that a user who must travel for medical reasons be accompanied. This must be indicated on the medical prescription as well as the reason. Users who are under 18 years of age may at any time be accompanied by one of their parents, without a medical prescription from the physician.

For questions or information, please contact us at 08.cierrat.pdu@ssss.gouv.qc.ca:

Rouyn-Noranda

Telephone: 819 764-5131, ext. 42104

Amos

Telephone: 819 622-2773, poste 4450

La Sarre

Telephone: 819 622-2773, poste 4450

Val-d'Or

Telephone: 819 764-5131, poste 42104

Oncology

Telephone: 1 833 637-2380

Ville-Marie

Telephone: 819 622-2773, ext. 4450

Section 1: THE USER (in block letter PLEASE)

First and last names: _____ File #: _____
Health insurance #: _____ Expiry date: _____
Name of parent if under 18 years of age: _____ Date of birth: _____
Address: _____
City: _____ Postal code: _____
Primary telephone #: _____ Telephone # (other): _____
Email address: _____

Are you receiving the following financial assistance?

Ministère de l'Emploi et de la Solidarité sociale (social assistance): Yes No
Transportation-accommodation program for people with disabilities: Yes No
CNESST (Commission des normes, de l'équité, de la santé et de la sécurité au travail): Yes No
Société de l'assurance automobile du Québec (SAAQ): Yes No

Mode of transportation used:

Outward trip > date of departure : _____ car bus transfer other: _____
Return trip > date of departure : _____ car bus transfer other: _____

PLEASE APPEND THESE ITEMS TO THIS FORM:

- Your bus receipts
- Your accommodation receipts (e.g.: loading house, hotel for cancer patients, hotel or short-term rental, campground)

The undersigned user declares that he or she has not received any sum that could cover all or part of the expenses being claimed and authorizes the CISSS de l'Abitibi- Témiscamingue to exchange any relevant information with the referring physician. The undersigned user declares that he or she has read the Politique de déplacement des usagers (user travel policy) and declares that they meet its criteria.

Signature: _____ Date: _____

SECTION RESERVED FOR THE INSTITUTION ** IMPORTANT: Do not subtract the 200-km deductible for cancer patients

Destination: Montréal Other: _____ Accompanying person requested by physician: Yes No
Outward trip > date of departure: _____ car bus transfer other: _____
Return trip > date of departure: _____ car bus transfer other: _____

Financial assistance allocated:

User: Transportation: \$ _____ Meals/accommodation: \$ _____ TOTAL: \$ _____ Budget: _____
Accompanying person: Transportation: \$ _____ Meals/accommodation: \$ _____ TOTAL: \$ _____ Budget: _____
Follow-up by: _____ File note: _____

Verified and authorized by: _____ Date: _____

Section 2: TRAVEL JUSTIFICATION

This section **MUST** be completed by the treating physician in Abitibi-Témiscamingue who is referring the user.

Appointment for oncology follow-up or diagnosis

Elective appointment:

Radiation therapy:

Diagnosis: _____

Specify the medical specialty required and not available in the region: _____

Specialized examination or treatment required: _____

Name of medical specialist or receiving physician: _____

Name of the institution where the user is being referred: _____

Please indicate the priority and the preferred timeframe for the consultation: _____

Does the RAMQ cover the care or services? Yes No Explanation: _____

Identification of the treating physician (in block letters): _____ Will there be subsequent visits? Yes No

Accompanying person required for the 1st visit: _____ Yes No Reason: _____

Accompanying person required for subsequent visits: Yes No Reason: _____

Signature of treating physician: _____ Date: _____

Section 3: CONFIRMATION OF APPOINTMENT AT A HEALTH INSTITUTION

This section **MUST** be completed by the physician or person in charge of the specialized department where the appointment(s) will take place.

Name of physician seen (in block letters): _____

Specialty: _____

Date of consultation: _____ Next consultation(s): _____

Institution to which the specialist is attached: _____

Signature of physician or authorized person at the receiving institution

Licence #

Date

Stamp: _____