Financial Support Request Form 2018 -- HTAPQ FOUNDATION

Reserved for the sole use of the HTAPQ Foundation
No : ______________________

First and last name: ________________________________
Place of residence (city): ___________________________
Age: ________ ***PH diagnosis*** (year): ________ ***Phone:*** ________________

MEDICAL FOLLOW-UP

HOSPITAL:

☐ **HGJ / JGH** ☐ **IUCPQ** ☐ **Other:** ______________________

DOCTORS:

☐ Dr David Langleben
☐ Dr Andrew Hirsch
☐ Name: ______________________
☐ Name: ______________________
☐ Dr Steve Provencher
☐ Dr Simon Martel
☐ Dr Genevieve Dion
☐ Dr Mathieu Simon
☐ Name: ___________________________
☐ Name: ___________________________
☐ Name: ___________________________

DOMESTIC AND FINANCIAL SITUATION

Marital status: ☐ Single ☐ Married ☐ Widow
☐ Common-law ☐ Separated ☐ Other: ____________________________

People under your care: ☐ Husband/Wife ☐ Kid(s) ☐ Other: ____________________________

Details (e.g.: number of kids in your care, ages, student, employed, disabilities, etc):

____

____

Income: **(**Use your most recent income tax declaration available **-** Revenue Québec)

PH patient: Total income (line #199 Qué): ____________________$

Type of revenues: ☐ Work ☐ QPP/ OAS ☐ Other pension/retirement pension
☐ Salary insurance ☐ Disability pension QPP ☐ Social assistance
☐ Others: ____

Family income: Include the amounts of **all family members** in your calculations

Total income (total of lines #199 Qué): ____________________________________$

Mandatory: Please join a copy of your most recent Notice of Assessment sent to you by Revenue Québec

Note: Send your request with all necessary documents to the following address:

Fondation HTAPQ, 1840, avenue Painchaud, Plessisville (Qué) G6L 2Z3

For more information, contact: info@htapquebec.ca

(complete back side)

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a) MEDICATIONS

Which ones? ____

____

Informations concerning your medication insurance coverage:

☐ Your own group plan ☐ Husband/wife/parent group plan ☐ RAMQ ☐ RAMQ exceptions

1) Franchise: ________ $; 2) Monthly coinsurance paid as of January 2017: ________ $ X 12 = ________ $

Total (1 + 2): ________ $

b) MEDICAL EQUIPMENT

☐ Wheel chair ☐ Walker ☐ Oxygen concentrator ☐ C-PAP

☐ Security device (shower chair/bar, seat, etc) ☐ Other

Details: ____

IMPORTANT: Communicate with the Foundation before purchasing or renting any equipment.

c) OXYGEN

Rental of a device (pump, tank) (amount per month): ______________$ X 12 months = _________________$ Total annually

Refill: __________$ per refill X ____________ number per month X 12 months = ______________________$ Total annually

d) HOSPITAL VISITS (for 1 visit only)

a) Parking: _______________________ $

b) Fuel: __________________________ $

c) Meals, if required: ______________ $

d) Housing, if needed: ______________ $

(1) Amount for one visit (a+b+c+d) = ___________________ $

(2) Number of planned visits in one year = ______________ $

(1) X (2) total = ____________________ $

e) HOME SUPPORT *(house cleaner,* laundry, meals, hygiene, etc)

Details: ____

____

On a 2-week basis: _________$ per hour _______ X number of hours = _______________$ total

Total for 2 weeks: _________________$ X 26 weeks = _______________$ annual total amount

NOTE: Supporting receipts shall be attached to demand.

f) OTHERS NEEDS / COMMENTS / DETAILS

____

____

____

Total amount of my request: __________ $

By signing this document, I authorize the HTAPQ Foundation to communicate, if needed, with my doctor(s)

______________________	____________________________________	________________________
Date	***Signature***	***City***