FINANCIAL SUPPORT REQUEST - FONDATION HTAPQ

Nu. of Request: _____

***First and Last Name*:** _____

Birth Date: _____

Place of Residence (city)**:** _____ ***Tel.:*** **( ) ____ - _____**

MEDICAL FOLLOW-UP

Which year did you received your pulmonary hypertension (PH) diagnosis? _____

In which hospital are you being treated for PH?

☐ Jewish General Hospital

☐ Institut universitaire de cardiologie et de pneumologie de Québec (IUCPQ)

☐ Other, specify: _____

Who is your PH doctor? _____

In which CLSC are you registered? _____

Type of PH: ☐ Pulmonary Arterial Hypertension (G-I); ☐ PH due to left heart disease (G-II);

☐ PH due to lung disease and/or chronic hypoxia (G-III); ☐ Chronic thromboembolic PH (CTEPH) (G-IV);

☐ PH due to blood and other disorders (G-V)

DOMESTIC SITUATION

Your marital status? ☐ Single; ☐ Married; ☐ Common law; ☐ Separated/divorced; ☐ Widower/Widow

Do you live alone*:* ☐ Yes; ☐ No

People under your care: ☐ Husband/Wife; ☐ Spouse; ☐ Child/Children; ☐ Other person(s); ☐ None

Details (e.g.: number of children under your care, ages, status (student, employed, invalid), other person(s) under your care, specify):

_____

_____

FINANCIAL SITUATION

***INCOME*:** (*Use your most recent income tax « avis de cotisation » issued by Revenu Québec)*

PH Patient: - What is your total income declared on line 199? $ _____

What are the sources of your income? ☐ Work; ☐ Retirement annuity; ☐ Social Assistance;

☐ Salary Insurance; ☐ Québec Disability Pension; ☐ Quebec Pension Plan/Old-Age Security;

☐ Guaranteed Income Supplement (GIS); ☐ Other(s), specify:_____

Family Income: (*Include incomes of* **all family members living with you** *in your calculations)*

- What is the total family income? (total of all lines #199 Qué): $ _____

***Mandatory*:** (**All copies** of the most recent income tax « avis de cotisation » issued by Revenu Québec must be included)

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

Fondation HTAPQ, care of: Mrs Andrée Trépanier, r.n.

1285 rue Rolland, Verdun (Qc) H4H 2G5

For more information or for help filling up the form:

contact Mrs Andrée Trépanier at (514) 732-0161 or by email : andreetrepanier@videotron.ca

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PHARMACARE PLAN

According to which pharmacare plan are you covered?

☐ Your own collective plan; ☐ Your spouse or parents' collective plan;
☐ RAMQ (Québec Pharmacare Plan); ☐ The RAMQ Program « Patient d'exception »

What is the annual cost of your deductible? $ _____(1)

What is the cost of your monthly co-payment: $ _____ X 12 months = $ _____(2)

Mandatory**:** *Include first bill of the year* **Total (1 + 2): $ _____**

MEDICAL EQUIPMENT USED

☐ Wheel Chair; ☐ Walker; ☐ Oxygen Concentrator; ☐ C-PAP;
☐ Safety Device (e.g.: shower and bath bar/chair, seat, etc.); ☐ Other(s) (specify):

Details : _____

_____

IMPORTANT : Contact the "Fondation" before purchasing or renting any equipment.

OXYGEN NEEDED

What is the monthly rental cost of your pump/tank? $ _____ X 12 months = $ _____(1)

What is the cost of a refill? : $ _____ X How many refills per year?_____= $ _____(2)

Mandatory**:** *Include the supporting documents* **Total (1 + 2): $ _____**

COST OF A HOSPITAL VISIT

What is the distance (one-way) between your home and the hospital you are treated for PH? _____ km

a) Public transportation: $ _____
b) Parking: $ _____
c) Fuel: $ _____
d) Meals (if required): $ _____
e) Lodging (is required): $ _____

Total amount for one visit (a+b+c+d+e) = $ _____

X Number of planned visits in one year = $ _____

_____

Total / year = $ _____

HOME SUPPORT NEEDED (Use a separate page if needed.)

Specify details (e.g.: house cleaning, laundry, meals, hygiene, etc.) and list incurred costs.

_____

Mandatory**:** *Include the supporting documents.*

OTHER NEEDS (Use a separate page if needed.)

Specify details and list incurred costs.

_____

IMPORTANT : Do not incur costs before submitting your request.

Mandatory**:** *Include the supporting documents (cost estimation).*

TOTAL AMOUNT OF MY REQUEST: $ _____

By signing this document, I authorize the "Fondation HTAPQ" to contact my PH doctor if need be.

_____ _____ _____

Date ***Signature*** ***City***