

Application Form for the Companion Leisure Card (CAL)

A Applicant Information – section to be completed by all			
First name		Last name	
Civic number	Street		Apt
City		Province	Postal code
Home phone	Office phone	Cell phone	
Gender :			
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other	
Email address			
Date of birth (YYYY-MM-DD)			

I need assistance with:			
<input type="checkbox"/>	Communicating with others	<input type="checkbox"/>	Feeding myself
<input type="checkbox"/>	Completing activities safely	<input type="checkbox"/>	Moving around
<input type="checkbox"/>	Helping me with my personal needs	<input type="checkbox"/>	Orienting myself
If applicable, include any other relevant information regarding your assistance needs:			

B Contact information for applicant's representative (if applicable)			
First name		Last name	
Home phone	Office phone		Cell phone
Email address			
Relationship with the person with a disability			
<input type="checkbox"/>	Father/mother	<input type="checkbox"/>	Curator
<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Guardian
<input type="checkbox"/>	Other:		

C Commitment and signature of the person requesting the card To be completed by all	
If I obtain the Companion Leisure Card, I agree to:	
-	Present the card to partner organizations that recognize it;
-	Choose a person capable of acting as an assistant and to meet my needs for an adequate and safe activity experience;
-	Inform the CAL team of any change of contact information, loss, theft, or damage of the card;
-	Respect the rule on not lending the card to another person.
I certify that the information I have provided to determine my eligibility for the card is true.	
Signature of applicant or representative	
Date (YYYY-MM-DD)	

Section D is to be completed by individuals who do not have proof of eligibility

D Authorization to disclose personal information for verification by a professional in the health and social services network	
I authorize the health care worker, whose name appears below, to confirm the information provided in section A for the sole purpose of accessing the CAL.	
First name of health worker	Last name of health worker
First name of applicant	Last name of applicant
Date of birth (YYYY-MM-DD)	
Signature of applicant or representative	
Date (YYYY-MM-DD)	

See the list of authorized health care workers in the guidelines document.

This authorization is valid for 90 days from the date of signature.

Section E must be completed by the health care professional

E		Attestation by a health or social services professional	
Based on the information available to me, I certify that the applicant, whose name appears below, requires support for the following reasons:			
<input type="checkbox"/>	Communicating with others	<input type="checkbox"/>	Feeding themselves
<input type="checkbox"/>	Completing activities safely	<input type="checkbox"/>	Moving around
<input type="checkbox"/>	Help with personal needs	<input type="checkbox"/>	Orienting themselves
If applicable, list any other pertinent information regarding their support needs:			
First name of applicant		Last name of applicant	
Date of birth (YYYY-MM-DD)			

Information on the health and social services professional

First name of health worker		Last name of health worker	
Name of the institution			
Civic number	Street		Apt
City		Province	Postal code
Phone	Fax	Email address	
Signature of the professional			Date (YYYY-MM-DD)
Profession			License No.

Optional section

This section of the form is optional. This information will remain confidential and will only be used to better understand the user's profile in order to offer you better services.

Please identify your primary disability by checking the appropriate box:

- Hearing impairment
- Language impairment (aphasia, dysphasia)
- Intellectual disability
- Motor/physical impairment
- Visual impairment
- Autism spectrum disorder
- Other :

Protection of personal information – information for all

The personal information collected is necessary to review your application. Only appropriate staff within the CAL team can access it.

The CAL is issued by the Association québécoise pour le loisir des personnes handicapées (AQLPH), with the support of the regional authorities responsible for leisure activities for people with disabilities and the financial support from the Government of Quebec.