2024

Application Form for the Companion Leisure Card (CAL)

Don't forget to attach to the form:

☐ Photo of the applicant (clear face, visible, no accessories)

☐ Proof of eligibility OR section E completed by health and social services worker/professional

☐ New request ☐ Renewal

A Applicant Information – section to be completed by all

First name	Last name	
Civic number	Street	Apt
City	Province	Postal code
Region		
Home phone	Office phone	Cell phone
Gender : ☐ Female ☐ Male ☐ Other		
Email address		
Date of birth (YYYY-MM-DD)		

I need assistance with:

☐ Communicating with others ☐ Feeding myself

☐ Completing activities safely ☐ Moving around

☐ Helping me with my personal needs ☐ 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

☐ Father/mother ☐ Guardian

☐ Spouse ☐ Other :

C Commitment and signature of the person requesting the Companion Leisure Card (CAL) – section 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:

- ☐ Communicating with others
- ☐ Feeding themselves
- ☐ Completing activities safely
- ☐ Moving around
- ☐ Help with personal needs
- ☐ Orienting themselves

Considering that the CAL must be renewed every 5 years, will the applicant still have the same support needs in 5 years?

☐ To validate ☐ Yes ☐ No

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)	

First name of health worker		Last name of health worker	
Name of the institution			
Civic number	Street		Office
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.