

Guidelines for Companion Leisure Card (CAL)

How to apply for your CAL ?

You must send a complete request. This includes:

- The CAL application form
- The sections D and E completed by health and social services worker/professional
- A photo of your face

Section D and E

Ask a health and social services worker/professional to complete the document.

The following professionals can complete this document:

- Audiologist
- Criminologist
- Specialized educator or specialized education technician
- Occupational therapist
- Nurse
- Respiratory therapist
- Family doctor (general practitioner)
- Specialist physician (cardiologist, pulmonologist, neurologist, psychiatrist, ophthalmologist, rheumatologist, etc.)
- Optometrist
- Speech Therapist
- Physiotherapist
- Psychoeducator
- Psychologist
- Specialist in visual impairment rehabilitation
- Specialist in orientation and mobility
- Social worker or social work technician
- Physical rehabilitation therapist

Which photo should I send and why ?

You must send a photo of your face. It will be printed on your CAL to identify you.

The photo must meet the following criteria :

- If you are emailing the photo or attaching it to your online application, the extension or format of the photo must be JPG.
- The photo can be taken with your cell phone.
- The photo must have been taken within the last six (6) months.
- The photo can be in black and white or in color.
- The photo must be clear : Your face should be clear, with no reflection in the glasses, no hat, and no shadow.

How to send the complete request ?

By email to: cal@aqiph.qc.ca please attach:

- Your form in a single file in “PDF” format
- Your proof of eligibility in “PDF” format or sections D and E (page 4)
- Your photo in “JPG” format

OR

Return the completed form and photo to :

AQLPH – CAL

25, rue des Forges, bureau 320

Trois-Rivières (Québec) G9A 6A7

Please enclose with your mailing:

- Your completed form
- Your proof of eligibility or section D and E
- Your photo (first and last name on the back)

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

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 :	<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

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:		
<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	
Considering that the CAL must be renewed every 5 years, will the applicant still have the same support needs in 5 years?		
<input type="checkbox"/> To validate	<input type="checkbox"/> Oui <input type="checkbox"/> Non	
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.	

Section facultative

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.