Fondation Moelle épinière et motricité Québec
Soutenir l'autonomie

Fondation33

APPLICATION FORM

FONDS 33

2021

For eligibility requirements, terms, dates, instructions, contact information, and other relevant information, please visit www.moelleepiniere.com/fonds-33 or inquire at the office of MEMO-Qc in Montreal.

Please fill out this financial support application form and return it either by email to fondation@moelleepiniere.com, by fax at (514) 341-8884 or by mail to 6020 Jean-Talon Street East, Suite 400, Montreal, Qc., H1S 3B1.

SECTION 1 - Claimant's Personal Information

First and last name of applicant _____

Address _____

Phone _____

Email _____

Relationship between the applicant and the recipient _____

If the applicant is the beneficiary, please go directly to section 3. If this is not the case, please complete section 2.

SECTION 2 - Beneficiary's Personal Information

First and last name of beneficiary_____

Address _____

Phone _____

Email _____

SECTION 3 - Identification

Sex _____

MEMO-Qc Membership Number _____

Date of birth _____

RAMQ _____ Expiration date_____

If you are not a native of Quebec, how long have you been a resident Quebec? _____

Date of injury _____

Diagnosis of the spinal cord injury

Tetraplegia _____ Lesion level _____ ASIA _____

Paraplegia _____ Lesion level _____ ASIA _____

Other _____

Moblity aid

Motorized wheelchair _____ Manual wheelchair _____

Other _____

Support provider, if applicable

CNESST _____ SAAQ _____ IVAC _____

Other _____

SECTION 4 - Family Situation

What is your marital status? _____

Do you live alone? YES _____ NO _____

If NO, with whom do you live? _____

Do you have dependent children? YES _____ NO _____

If YES, how many? _____

SECTION 5 - Financial Support

What is the amount requested?

_____

SECTION 6 - Reason for the Request

What will the amount requested be used for?

_____

_____

_____

_____

_____

_____

_____

SECTION 7 - Financial Situation

ANNUAL GROSS INCOME	BENEFICIARY	SPOUSE
Employment income **INCOME**	_____ $ / year	_____ $ / year
Unemployment Insurance Benefit **INCOME**	_____ $ / year	_____ $ / year
Other _____	_____ $ / year	_____ $ / year

ANNUAL INCOME NET	BENEFICIARY	SPOUSE
Support agents (CNESST, SAAQ, IVAC)	**NET** _____ $ / year	_____ $ / year
Employment insurance income replacement	**NET** _____ $ / year	_____ $ / year
Private insurance	**NET** _____ $ / year	_____ $ / year
Disability pension (QPP)	**NET** _____ $ / year	_____ $ / year
Scholarship	**NET** _____ $ / year	_____ $ / year
Social assistance or Parental Insurance Plan	**NET** _____ $ / year	_____ $ / year
Family Allowance	**NET** _____ $ / year	_____ $ / year
Retirement pension	**NET** _____ $ / year	_____ $ / year
Old Age Security Pension (OAS)	**NET** _____ $ / year	_____ $ / year
Other _____	**NET** _____ $ / year	_____ $ / year

ADDITIONAL EXPENSES DIRECTLY RELATED TO YOUR DISABILITY

_____

_____

_____

SECTION 8 - Additional Information

Please enter any additional information that you feel is useful, that demonstrates your need for financial assistance.

_____

_____

_____

_____

_____

SECTION 9 - Supporting Documents

Please attach the following supporting documents:

MANDATORY

Proof of income (RL-1, T4 and / or pay stub) (**Please hide your social insurance number*)

Submissions and / or quotes

OPTIONAL

An occupational therapist report (MAX: two pages)

Any other relevant documents (MAX: two documents)

SECTION 10 - Declaration

I hereby declare that all the information provided is true and complete and that all related documents are true.

Signature _____ Date _____