

Avec vous,
au cœur de votre sécurité

Accident victim (last name and first name)

Claim Number

SECTION 1 – ELIGIBILITY

You could be entitled to the reimbursement of expenses incurred for personal home assistance services due to an accident-related condition, where your physical or mental condition prevents you from taking care of yourself or carrying out activities of daily living on your own.

The weekly amount to which you are entitled is determined based on the period for which assistance is claimed and further to analysis by the SAAQ. This amount is adjusted based on any improvement or deterioration in your state of health.

SECTION 2 – GENERAL INFORMATION

(Enter the start and end dates of the period for which you are applying for the reimbursement of personal home assistance expenses.)

This description of your needs is for the period from

Year Month Day to Year Month Day

Were you hospitalized, in temporary lodging or in rehabilitation during this period? Yes No

If so: Start date Year Month Day End date Year Month Day

Where were you staying during the period covered by the claim? At home Elsewhere (specify):Were you living alone? Yes If not, specify:Were any features of this residence problematic for you Yes No

If so, please specify: (stairs, bathroom access, laundry room location, etc.)

Did you have any equipment or accessories that gave you more independence? Yes No

If so, please specify: (bath seat, grab bar, raised toilet seat, reaching aid, etc.)

During this period, did you receive services from a CLSC or another health care agency? Yes No

If so, please specify: (dressing changes, intravenous antibiotics injections, etc.)

Please check off any material or equipment used during this period. Where applicable, please indicate the date on which you stopped using each item.

<input type="checkbox"/> 1 or <input type="checkbox"/> 2 canes	until (Year-Month-Day):	<input type="checkbox"/> Brace	until (Year-Month-Day):
<input type="checkbox"/> 1 or <input type="checkbox"/> 2 crutches	until (Year-Month-Day):	<input type="checkbox"/> Orthosis/prosthesis/splint	until (Year-Month-Day):
<input type="checkbox"/> Walker	until (Year-Month-Day):	<input type="checkbox"/> Cervical collar	until (Year-Month-Day):
<input type="checkbox"/> Wheelchair	until (Year-Month-Day):	<input type="checkbox"/> Pressure stockings	until (Year-Month-Day):
<input type="checkbox"/> Cast	until (Year-Month-Day):	<input type="checkbox"/> Other:	until (Year-Month-Day):

What are the significant medical events **during this period** that justify your application?

(injuries sustained as a result of the accident, surgery, complications, tests, treatments, etc.)

You are: Right-handed Left-handed**Before the accident**, did you drive? Yes No **And now**, do you drive? Yes No**Complete the following if this is your first time applying****Before the accident**, were you receiving services at home? Yes No

If so, please check off which ones and indicate the frequency.

<input type="checkbox"/> Assistance with bathing:	<input type="checkbox"/> Laundry services:
<input type="checkbox"/> Housekeeping services:	<input type="checkbox"/> Home delivery (groceries, medication):
<input type="checkbox"/> Meal preparation services:	<input type="checkbox"/> Other (please specify):

Other details regarding your condition during the period covered by this claim:

AP



SECTION 3 – NEEDS ASSESSMENT (Check off the level of assistance required for each activity.)

During the period indicated in Section 2, I carried out the activity →	Unassisted	Unassisted but with difficulty	With some assistance	With much assistance	I did not carry out that activity before the accident
Personal hygiene					
■ Getting in and out of the bathtub or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Washing every part of your body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Washing your hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Shaving, grooming, caring for your hair, applying makeup, trimming your nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing/undressing					
■ Upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Lower body (includes putting on shoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating					
■ Bringing food to your mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Cutting food on your plate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Serving yourself a beverage at the table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of toilet					
■ Sitting on the toilet or commode and standing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Wiping yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Rearranging clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medication <input type="checkbox"/> Not applicable (taking pills; applying creams, ointments, drops, bandages)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on/taking off <input type="checkbox"/> Not applicable <input type="checkbox"/> Brace <input type="checkbox"/> Cervical collar <input type="checkbox"/> Prosthesis <input type="checkbox"/> Splint/orthosis <input type="checkbox"/> Pressure stockings <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of facilities at home					
■ Moving about inside your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Entering and leaving your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Opening and closing the windows and doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Using the telephone, remote controls and switches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of your principal mode of transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please specify: <input type="checkbox"/> Automobile <input type="checkbox"/> Bus <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing a light meal for yourself					
(planning and preparing two meals per day, such as making breakfast or a sandwich, reheating a meal, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing a complex meal for yourself					
(planning and preparing one meal per day requiring several steps in its preparation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily housekeeping					
■ Washing dishes (by hand or filling/emptying the dishwasher)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Wiping counters and the table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Putting things away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Making your bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Sweeping the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly housecleaning					
■ Dusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Vacuuming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Cleaning the bathtub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Taking out the garbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Annual spring cleanup (washing walls, ceilings, cupboards, carpets, windows)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry					
■ Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Drying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Folding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Carrying and putting away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping and services					
■ Planning and making purchases and booking personal appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Travelling to a place of business or public service (grocery store, bank, post office, drugstore, ATM, shops, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Selecting and paying for items (at the place of business, by telephone or online)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Carrying bags and parcels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Budget management					
(managing personal income and expenses, writing a cheque, paying bills, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THERE ARE THREE WAYS TO SUBMIT A DOCUMENT:

Through the Document Submission and Reimbursement of Expenses online service for external service providers: saag.gouv.qc.ca/documentsintervenants

By fax: 1-866-289-7952

By mail: Société de l'assurance automobile du Québec
Case postale 2500, succursale Terminus
Québec (Québec) G1K 8A2

Keep the original or a copy for your files.

Signature

Date

Année Mois Jour

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