Centre intégré de santé et de services sociaux des Laurentides

Québec \* \*

## USER CLAIM FORM FOR LOSS, DAMAGES OR OTHER PERSONAL PROPERTY

Direction des ressources financières

Surname	First Name	File #
Birthdate		
Address		Apt.#
•	Province	Postal Codo
Phone - Home	Work	
		S
	can be reached within the facility	
Room #	Unit, service or department	
. CLAIMANT		
User/Resident	Representative Other – Specif	y:
. STATUS OF THE REPRE		
First Responder	Spouse Proxy Sign	nificant other – Specify:
□ Legal Heir □ G	uardian or Trustee	
Legal Guardian :	ualulari or musice other specify.	
. CONTACT INFORMATI	ION OF THE CLAIMANT (IF DIFFERENT THAI	N USER/RESIDENT INFORMATION)
Surname	First Name	
Address		Apt. #
City	Province	Postal Code
	Work Ext. #	
Phone - Home		
		Ext. #
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the	E-mail address	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility	E-mail address	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event	E-mail address  EVENT  ne facility which is the object of a claim	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event (Year/Month/Day)	E-mail address  EVENT  ne facility which is the object of a claim  Time	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility  Location Date of event (Year/Month/Day)  Subject of the claim:	E-mail address  EVENT  Time  Loss  Damage  Total	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event (Year/Month/Day) Subject of the claim:	E-mail address  EVENT  Time  Loss  Damage  Total	
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event (Year/Month/Day) Subject of the claim: Name of witness, if appli	E-mail address  EVENT  Time  Loss  Damage  Total	
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Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event (Year/Month/Day) Subject of the claim: Name of witness, if appli  5.2 Description of the Dentures: Up Hearing aid: Le Contact lenses Other Specify: Nb of years of use/wear:	E-mail address  EVENT  ne facility which is the object of a claim  Time  Loss Damage T  icable:  subject of the claim (loss/damage)  oper Lower  eft Right  Eye glasses Clothing - Specify:  0-1 years 2-3 years	Theft Other – Specify:  4-10 years
Cell. Phone  DESCRIPTION OF THE  5.1 Identification of the Name of facility Location Date of event (Year/Month/Day) Subject of the claim: Name of witness, if appli  5.2 Description of the Dentures: Up Hearing aid: Le Contact lenses Other Specify: Nb of years of use/wear:	E-mail address  EVENT  ne facility which is the object of a claim  Time  Loss Damage T  icable:  subject of the claim (loss/damage)  oper Lower  eft Right  Eye glasses Clothing - Specify:	Theft Other – Specify:  4-10 years
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This form must be filled out and sent to the mailbox <u>comptabilité-générale.cissslau@ssss.gouv.qc.ca</u> as well as forms AH-223, the list of personal property, the form of claiming a user for breakage, losses property or other (appendix 3) and any other relevant documents such as purchase and replacement invoices. Thank you!

6. COST ESTIMATE					
Cost of replacement:	ost of replacement: Estimate is attached				
Original cost: Approximate estimation:					
Date of purchase, if known:	Receipt/Proof of purchase?	Yes (Attach receipt/proof of purchase)	□No		
7. SIGNATURE OF CLAIMANT					
Claimant Name	Signa	ture	Date (Year/Month/Day)		
• Important note: To be receivable, the claim must be presented in a timely manner, soon after the damage to, or the loss of, personal property/valuable object is discovered.					
• The duly completed form must be submitted to the chief of service, or his/her representative, of the unit (health care unit, emergency unit or other) where the damage to, or the loss of property occurred.					
We ask you to note down the name	ne and business phone nu	mber of the person rece	eiving your claim form.		
8. RECEIPT CONFIRMATION OF THE C	LAIM FORM				
Claim received by:			On:		
Name	Signa		Date		
			(Year/Month/Day)		