|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Your personal information: Personal information collected by Queensland Health is handled in accordance with the Information Privacy Act 2009. Your personal information is being collected in order to assess whether you are eligible to receive an accommodation subsidy under the patient travel subsidy scheme. The personal information provided by you will be securely stored and made available to appropriately authorised officers of Queensland Health. Personal information recorded on this form will not be disclosed to other parties without your consent, unless required by law. For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at ww.health.qld.gov.au | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Important:** Patient Travel Subsidy Scheme (PTSS) applications must be submitted to the patient's closest public hospital or health facility for assessment prior to travel. Where available, copies of the referral and / or appointment letter relating to this application are to be attached.  Please **retain a copy** of the completed form and supporting documents (where applicable) for your own records. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Section 1: Patient details** | | | | | | | | | | | | | | | | | | | | |
| * **Patient** to complete | | | | | | | | | | | | | | | | | | | | |
| Title | Given name(s) | | | | | | | | | | Family name | | | | | | | | | |
| Preferred name (if applicable) | | | | | | | | | | | Date of birth | | | | | Contact number | | | | |
| Residential address | | | | | | | | | | | Suburb / Town | | | | | | Postcode | | |
| Postal address (if different to residential address) | | | | | | | | | | | Suburb / Town | | | | | | Postcode | | |
| Email address | | | | | | | | | | | | | | | | | | | | |
| Are you of Aboriginal and / or Torres Strait Islander origin?  Yes  No | | | | | | | | | | | | | | | | | | | | |
| Please tick if any of the following apply to you:  I have received a PTSS accommodation subsidy within the last financial year (1 July to 30 June)  I am accessing treatment as a private patient or through private health cover  I have lodged / intend to lodge a third party or Workers Compensation Claim relating to this treatment | | | | | | | | | | | | | | | | | | | | |
| Concession / Benefit card (tick one if applicable):  Department of Veterans Affairs (Gold / White)  Centrelink Health Care Concession Card  Pensioner Concession Card  Commonwealth Seniors Health Card | | | | | | | | | | | Card number    Expiry date (MM / YY)     / | | | | | | | | | |
| Medicare card number | | | | | | | | | | | Expiry date (MM / YYYY)     / | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Section 2: Appointment** | | | | | | | | | | | | | | | | | | | | |
| * **Patient**, **referring** **clinician** (or clinician's nominated representative) or **approving** **hospital** to complete * If completed by patient, evidence of appointment must be provided (e.g. copy of confirmation letter or appointment card) | | | | | | | | | | | | | | | | | | | | |
| Date | | | Time | | | | | Patient will be treated as a Public or Private patient?  Public  Private | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3: Patient declaration** | | | | | | | | | | | | | | | | | | | | | | |
| * **Patient** and / or **Guardian / Carer** to complete | | | | | | | | | | | | | | | | | | | | | | |
| The information that I have provided is true and accurate at the time of application. I give my permission for hospital staff to obtain information about my medical condition for the purposes of this application and provide to the treating facility as required. I give permission for hospital staff to forward transport and accommodate on details to relevant providers as is required. I consent for the subsidy to be provided directly to my transport and / or accommodation provider under a bulk-billing arrangement if available. I certify that any subsidies provided to me will be used for the purposes of travelling to access the stated specialist service. | | | | | | | | | | | | | | | | | | | | | | |
| Patient signature | | | | | | | | | | | | | | | | | | Date | | | | |
| Guardian / Carer name | | | | | | | | | | | | Signature | | | | | | Date | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4: Referral** | | | | | | | | | | | | | | | | | | | | |
| * **Referring clinician** (or clinician's nominated representative) to complete * Complete if referral letter / appointment letter does not contain the below information | | | | | | | | | | | | | | | | | | | | |
| Patient name | | | | | | | | | | | | | | | | Date of birth | | | | |
| Specialist name | | | | | | | | | Specialty type | | | | | | | | | | | |
| Reason for travel (patient diagnosis / current condition) | | | | | | | | | | | | | | | | | | | | |
| Facility name | | | | | | | | | Facility location | | | | | | | | | | | |
| Is this the nearest specialist?  Yes  No  *If no, provide reason.* | | | | | | | | | | | | | | | | | | | | |
| Reason | | | | | | | | | | | | | | | | | | | | |
| Clinically recommended mode of travel:  Rail  Bus  Air  Private motor vehicle  Other | | | | | | | | | | | | | | | | | | | | |
| Clinical reason for mode of travel | | | | | | | | | | | | | | | | | | | | |
| Does the patient require special travel requirements?  Wheelchair  Oxygen  Other        No | | | | | | | | | | | | | | | | | | | | |
| Does the patient require accommodation?  Yes  No  *If yes, provide reason.* | | | | | | | | | | | | | | | | | | | | |
| Reason | | | | | | | | | | | | | | | | | | | | |
| Does the patient require an escort?  Yes  No  *If yes, provide reason.* | | | | | | | | | | | | | | | | | | | | |
| Clinical reason    *If clinically approved, complete escort details.* | | | | | | | | | | | | | | | | | | | | |
| Escort name | | | | | | | | | | | | | | Escort date of birth | | | | | | |
| Does the escort require accommodation?  Yes  No | | | | | | | | | | | | | | | | | | | | |
| **Referring clinician (or clinician's nominated representative) declaration** | | | | | | | | | | | | | | | | | | | | |
| I certify that the information above is correct. I give permission for Hospital and Health Service staff to contact the referring facility regarding this application. | | | | | | | | | | Provider stamp / label | | | | | | | | | | |
| Name | | | | | | | | | |
| Signature | | | | | | | | | |
| Contact number | | | | Date | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Section 5: Assessment and approval** (admin use only) | | | | | | | | | | | | | | | | | | | | |
| * **Approving officer** to complete | | | | | | | | | | | | | | | | | | | | |
| Proof of residency sighted  Concession card sighted | | | | | | | | | | | | | | | | | | | | |
| **Patient** | | Date form | | | Date to | | Type | | | | | | | | Approved | | | | Not approved | |
| PTSS | |  | | |  | |  | | | | | | | |  | | | |  | |
| Accommodation | |  | | |  | | Commercial  Private / Family | | | | | | | |  | | | |  | |
| Transport | |  | | |  | | PMV  Train  Bus  Flight  Ferry  Other | | | | | | | |  | | | |  | |
| **Escort** | | Date form | | | Date to | | Type | | | | | | | | Approved | | | | Not approved | |
| PTSS | |  | | |  | |  | | | | | | | |  | | | |  | |
| Accommodation | |  | | |  | | Commercial  Private / Family | | | | | | | |  | | | |  | |
| Transport | |  | | |  | | PMV  Train  Bus  Flight  Ferry  Other | | | | | | | |  | | | |  | |
| **PTSS approval (or delegate)**  I authorise that this travel / accommodation is medically required. | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | Signature | | | | | | Date | | | |
| **Financial delegate approval**  I authorise that this travel / accommodation is medically required. | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | Signature | | | | | | Date | | | |
| **PTSS not approved:** provide reason for non-approval | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Office use only** | | | | | | | | | | | | | | | | | | | | | | |
| Facility / Unit record number | | | | | | Vendor number | | | | | | | PTSS application number | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |