Queensland Government

Patient Travel Subsidy Scheme (PTSS)

Application

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 www.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 (DD/MM/YY) | Contact number

Residential address | Suburb / Town | Postcode

Postal address (if different to residential address) | Suburb / Town | Postcode

Email address

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 (DD/MM/YY) | Time (H:MM) ☐☐ : ☐☐ ☐ AM ☐ PM

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 accommodation 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 (DD/MM/YY)

Guardian / Carer name | Signature | Date (DD/MM/YY)

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 (DD/MM/YY)

Specialist name

Speciality type

Facility name

Facility location

Is this the nearest specialist?

☐ Yes ☐ No

If no, provide 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

Does the patient require an escort?

☐ Yes ☐ No

If yes, provide clinical reason

Escort name (if clinically approved)

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.

Signature

Contact number

Date (DD/MM/YY)

Provider stamp / label

Section 5: Assessment and approval (admin use only)

• **Approving officer** to complete

☐ Proof of residency sighted ☐ Concession card sighted

Patient	Date from	Date to	Type	Approved	Not approved
PTSS				☐	☐
Accommodation			☐ Commercial ☐ Private / Family	☐	☐
Transport			☐ PMV ☐ Train ☐ Bus ☐ Flight ☐ Ferry ☐ Other	☐	☐

Escort	Date from	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 (DD/MM/YY)

Financial delegate approval
I authorise that this travel / accommodation is medically required.

Name	Signature	Date (DD/MM/YY)

PTSS not approved: provide reason for non-approval

Office use only

Facility / Unit Record number	Vendor number	PTSS application number

Notes

Queensland Government

Patient Travel Subsidy Scheme (PTSS)

Specialist Certification

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Important: Complete one form per specialist. A separate Specialist Confirmation form should be completed for each additional specialist treating the patient.
Please **retain a copy** of the completed form and supporting documents (where applicable) for your own records.

Section 1: Certification

- **Specialist** (or specialist's nominated representative) to complete
- Affix label or stamp (specialist details must include name, specialty, location and provider number)

Patient details	Specialist details

Section 2: Single trip specialist treatment

- **Specialist** (or specialist's nominated representative) to complete

Outpatient

Appointment date (DD/MM/YY) Appointment time (H:MM)

☐ AM ☐ PM

Inpatient

Admission date (DD/MM/YY) Admission time (H:MM)

☐ AM ☐ PM

Discharge date (DD/MM/YY) Discharge time (H:MM)

☐ AM ☐ PM

Tick to indicate if any of the following apply:

☐ A change to the above date(s) / time(s) affects the patient's current travel / accommodation bookings

Please contact the closest public hospital or health facility to the patient's residential address. Contact numbers are located at www.health.qld.gov.au/services/.

☐ Future treatments required

Please refer to Section 3: Future treatments.

☐ Commercial flight medical clearance required

Please ensure that the patient is provided with a signed Commercial Flight Clearance form for the airline they are travelling with.

Additional notes

Section 3: Future treatments

• **Specialist** (or specialist's nominated representative) to complete

Provide details of future appointments / admissions and send to the closest public hospital or health facility to the patient's residential address, for all future travel and accommodation to be booked.

Please note: PTSS subsidies for future appointments and ongoing treatment must be separately approved before any treatments identified below.

Outpatient appointments

Appointment		Clinic details	Escort required	Specialist declaration	
Date	Time	Name / Location	Yes / No	Signature	Date
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		

Inpatient admissions

Admission		Discharge		Clinic details	Escort required	Specialist declaration	
Date	Time	Date	Time	Name / Location	Yes / No	Signature	Date
					☐ Y ☐ N		
					☐ Y ☐ N		
					☐ Y ☐ N		
					☐ Y ☐ N		

Section 4: Specialist declaration

• **Specialist** (or specialist's nominated representative) to complete

I certify that the information in this form is correct and has been completed by myself. I give my permission for the approving hospital's Medical Superintendent to contact me regarding my certification of the patient's treatment.

Signature	Date (DD/MM/YY)

Section 5: Patient declaration

• **Patient** and / or **guardian / carer** to complete

I certify that the information on this form is correct and that all expenditure claimed was actually incurred and related to the provision of my / my dependents health care. I acknowledge that claims may not be paid without accompanying receipts / tax invoices.

Patient signature	Date (DD/MM/YY)

Guardian / Carer name	Signature	Date (DD/MM/YY)

Office use only

Facility / Unit Record number	Vendor number	PTSS application number

Notes