PATIENT TRAVEL SUBSIDY SCHEME (PTSS) – APPLICATION FORM

INFORMATION ABOUT THE PTSS

Purpose of the Scheme
Queensland Health's Patient Travel Subsidy Scheme (PTSS) provides assistance to patients who need to access essential specialist medical services, which are not available within their local area.

The Scheme may also provide a subsidy to assist people required to accompany the patient on medical grounds (the escort).

Eligibility
To be eligible, a patient must:
- Be a resident of Queensland;
- Hold or be eligible to hold a Medicare Card; and
- Be referred by a medical practitioner to a specialist medical service classified as "essential" under the Scheme.

The service to which a patient is referred must also:
- be at least 50km from their nearest public hospital; and
- be the nearest available specialist.

Patients requiring medical attention whilst interstate for work or holidays are not eligible for assistance.

Travel Assistance
If approved, assistance is provided towards the cost of the least expensive form of public transport covering travel from the transport terminal in the town of the patient's nearest public hospital, to the transport terminal in the town to which a patient has been referred.

Air travel is only considered when necessary for medical reasons.

Alternatively, a patient may choose to travel by private car. In these instances, a patient is subsidised at 15 cents per kilometre from the post office closest to their nearest hospital to the post office nearest to the hospital to which they were referred.

No assistance is provided for the cost of travelling between a transport terminal and a patient's residence, treating hospital, or approved accommodation provider.

Accommodation Assistance
Patients who hold specific concession cards or who are dependents younger than 17 years of age, receive assistance from the first night. All other patients and their approved escorts must each pay for the first four nights of accommodation per financial year.

If approved, assistance is provided up to $30.00 per person per night for commercial accommodation and $10.00 per person per night if a patient chooses to stay with friends or relatives.

In cases where long term accommodation is required, the approving hospital reserves the right to discuss options with the patient.

General Enquiries and Further Information
All applications to and enquiries about the Scheme must be forwarded to a patient's nearest public hospital.

Further information is available from Hospitals, Community Health Centres, and the Queensland Health internet site, *http://www.health.qld.gov.au*

HOW TO APPLY

1. A patient is referred by their medical practitioner to a specialist medical service that is not available locally.

2. The patient/guardian or carer completes Form A, and the referring Medical Practitioner completes Form B.

3. Prior to departure the patient/guardian or carer lodges Forms A and B at their nearest public hospital (the approving hospital).

4. The Medical Superintendent of the approving hospital assesses the application. If the patient is approved, hospital staff will notify the patient/guardian or carer and issue them with whichever forms they will require whilst the patient receives treatment. These forms may include:
   - Form C2: Approval Notice;
   - Form D1: Certification by Specialist;
   - Form D2: Recommendation for Patient to Return Home;
   - Form D3: Ongoing Specialist Treatment; and
   - Form E: Patient Declaration Form.

5. Form C2 is to notify a patient/guardian or carer of the specific assistance they will receive through the Scheme. This notification can also be used to prove eligibility under the Scheme to accommodation venues with direct billing arrangements with Queensland Health and lists contact details of the approving hospital.

6. Form D1 is to be taken by the patient/guardian or carer to the referred specialist medical service, where it must be completed after treatment by the treating specialist to whom they were referred.

   Form D1 can also be used if the patient is receiving treatment over a longer period of time and needs to make a claim for reimbursement before completion of treatment. In these instances, the patient/guardian or carer should contact staff at their approving hospital to discuss.

   The completed Form D1 must be returned to your approving hospital in order to claim your subsidy.

7. Form D2 is used in instances where a patient who has not had return travel booked is ready to return home or for patients where travel arrangements originally approved have changed as a result of their treatment.

8. Form D3 is only completed if ongoing specialist treatment is required. It is essential this form is completed by the treating specialist and returned to the patient/guardian or carer.

   If Ongoing Specialist Treatment has been approved, a patient should remain in close contact with their approving hospital to ensure appropriate bookings are made, and all necessary paperwork is completed.

9. After treatment has been completed, the patient returns home. In order for a claim to be made for any reimbursement through the Scheme, a patient/guardian or carer is required to complete Form E and where relevant provide receipts from accommodation venues or privately funded travel. Form E is lodged at the patient's nearest public hospital. Payment made directly to patients/guardians or carers will be by cheque or Electronic Funds Transfer at the approving hospital's discretion.

PATIENT TRAVEL SUBSIDY SCHEME (PTSS)

FORM A – PATIENT DETAILS
Patient/Guardian or Carer Completes

THIS FORM MUST BE LODGED PRIOR TO TRAVEL.
ALL QUESTIONS MUST BE ANSWERED.

PATIENT DETAILS

1. Patient's full name

Title ☐ Family Name (Surname) ☐

Given Names ☐

2. Patient's date of birth ☐

3. Patient's permanent residential address

☐
☐
City/Town
Postcode

4. Patient's postal address (if different)

☐
☐
City/Town
Postcode

5. Patient's telephone numbers

Home
Work
Mobile

6. Do you hold one of the following:

Medicare Card?
☐ No
☐ Yes Card No. ☐

Centrelink Card?
☐ No
☐ Yes Card No. ☐
Expiry Date ☐

Department of Veterans' Affairs Card?
☐ No
☐ Yes

Commonwealth Seniors Card?
☐ No
☐ Yes

7. Do you identify as being of Aboriginal or Torres Strait Islander origin?
☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander
☐ Yes, Aboriginal and Torres Strait Islander

8. Does this application relate to involvement in an accident?
☐ No
☐ Yes

9. Have you lodged, or do you intend to lodge a Third Party or Workers Compensation Claim Form relating to this application?
☐ No
☐ Yes

If a patient is entitled to receive compensation, from an Insurance Company, Workcover, etc, they may not be eligible for PTSS, or may be required to reimburse any PTSS subsidies they receive.

ESCORT DETAILS

TO BE COMPLETED WHERE A PATIENT'S REFERRING MEDICAL PRACTITIONER HAS RECOMMENDED A NEED FOR AN ESCORT.

10. Escort's full name

Title ☐ Family Name (Surname) ☐

Given Names ☐

11. Escort's telephone numbers

Home
Work
Mobile

DECLARATION

The information that I have provided is true and accurate at the time of application.

I give my permission for the approving hospital's Medical Superintendent to obtain information about my medical condition for the purpose of assessing my eligibility.

I give my permission for the approving hospital to forward my approval details (as per Form C2) to the treating hospital and/or accommodation provider when relevant.

I give my permission for the Certification by Specialist (Form D1) to be provided to accommodation providers where necessary to finalise billing arrangements.

Name (printed) ☐

Signature of Patient/Guardian or Carer ☐

Date

APPROVING HOSPITAL USE ONLY

PTSS No.:	
DISTRICT:	
COST CENTRE:	

PATIENT TRAVEL SUBSIDY SCHEME (PTSS)

FORM B – REFERRAL DETAILS
Medical Practitioner Completes

THIS FORM MUST BE LODGED PRIOR TO TRAVEL.
ALL QUESTIONS MUST BE ANSWERED.

REFERRAL DETAILS

1. Name of Patient

2. Patient diagnosis/Current condition

3. Reason for referral/Procedure required

4. Facility referred to
Facility
City/Town

5. Specialist referred to
Name
Speciality

6. Is this the nearest specialist for the patient to be referred to?
☐ No
☐ Yes ▸ Go to Question 8

7. If this is not the nearest specialist, give medical reasons for referral to this specialist?

Referrals to specialists that are not the nearest to a patient's place of residence is at the determination of the approving hospital's Medical Superintendent.

8. Appointment details
Date
Time

9. Patient status at referred facility
☐ Public ☐ Private

10. Recommended mode of travel
☐ Private Motor Vehicle
☐ Surface Transport (Rail or Bus)
☐ Air Transport ▸ Go to Question 11

11. Medical reasons for air travel?

Air travel is only approved under the PTSS based on medical grounds.

12. Will the Patient require accommodation?
☐ No ▸ Go to Question 13
☐ Yes
If Yes, please provide details (days/dates, etc)

13. Does the Patient have any special requirements?
☐ None ☐ Wheelchair
☐ Stretcher ☐ Ambulance
☐ Oxygen ☐ Drip
☐ Forklift ☐ Humidicrib
☐ Other ▸

14. Is an Escort (eg. spouse or partner) required to provide critical support to the patient?
☐ No ▸ Go to Question 17
☐ Yes

15. Please state medical reasons for an Escort to be considered

Escorts are only approved on medical grounds, (eg. patient requires oxygen, sedation, parenteral analgesia or for dependent children under 17).

16. In which of the following situations is an Escort recommended:
☐ Travel
☐ Duration of the entire In-Patient Stay
☐ Critical period of the In-Patient stay days
☐ Duration of the Outpatient Stay

MEDICAL PRACITIONER DETAILS

17. Name

18. Practice address and contact details
City/Town
Postcode
Telephone

DECLARATION

I certify that the information in Form B is correct and has been completed by me.

I give permission for the Medical Superintendent of the approving hospital to contact me regarding this referral.

Name (printed)

Signature of Medical Practitioner

Date

PATIENT TRAVEL SUBSIDY SCHEME (PTSS)

FORM D1 – CERTIFICATION BY SPECIALIST

Specialist Completes

TO BE COMPLETED AFTER TREATMENT, OR WHERE THE PATIENT INTENDS TO MAKE AN INTERIM CLAIM FOR REIMBURSEMENT. ALL QUESTIONS MUST BE ANSWERED.

SPECIALIST DETAILS (or affix Specialist stamp)

1. Specialist

Name
Speciality

2. Specialist address and details

City/Town
Postcode
Telephone

PATIENT DETAILS (or affix Patient label)

3. Patient Details

Name:
Date of Birth:
UR No.:
Address:
Telephone:

TREATMENT DETAILS

4. Patient received In-patient treatment:

☐ No
☐ Yes

If Yes, please detail dates:

Date From	Date To

5. Patient received Outpatient treatment:

☐ No
☐ Yes

If Yes, please detail dates:

Date From	Date To

6. Excluding hospitalisation, was it a medical necessity for the Patient to stay overnight?

☐ No
☐ Yes

If Yes, please provide relevant details:

7. Has the Patient's treatment been completed?

☐ No
☐ Yes

If an interim claim for reimbursement will be made, the treating specialist will be required to complete multiple certifications (Form D1) during the course of treatment.

8. Does return travel or alternative return travel need to be arranged for the Patient?

☐ No
☐ Yes ▸ Complete Form D2

9. Does the Patient require ongoing specialist treatment?

☐ No
☐ Yes ▸ Complete Form D3

ESCORT DETAILS

10. Name

11. Was it necessary for medical reasons for the Escort stay:

a) During the Patient's hospitalisation?

☐ No
☐ Yes
☐ Not Applicable

b) During the Patient's outpatient treatment?

☐ No
☐ Yes
☐ Not Applicable

If Yes to any of the above questions, please provide details/reason

DECLARATION

I certify that the information in Form D1 is correct and has been completed by me.

I give my permission for the approving hospital's Medical Superintendent to contact me regarding my certification of the patient's treatment.

Name (printed)

Signature of Specialist

Date

TREATING HOSPITAL FAX: ☐

IF THE PATIENT'S RETURN TRAVEL HAS NOT PREVIOUSLY BEEN BOOKED OR TRAVEL REQUIREMENTS HAVE CHANGED FROM THOSE ORIGINALLY APPROVED, COMPLETE FORM D2.

IF THE PATIENT REQUIRES ONGOING SPECIALIST TREATMENT, COMPLETE FORM D3.

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FORM D2 – RECOMMENDATION FOR PATIENT TO RETURN HOME

Specialist Completes

TO BE COMPLETED AFTER TREATMENT. ALL QUESTIONS MUST BE ANSWERED.

1. Patient Details (or affix Patient label)

Name:

Date of Birth:

UR No.:

Address:

Telephone:

2. The above referenced Patient will be ready to return home

Date

Time

3. Patient Destination

4. Mode of transport recommended:

☐ Air Transport

☐ Surface Transport

Type

Reason

Air Travel is only approved under the PTSS based on medical grounds.

Special requirements for the Patient to return home:

☐ None ☐ Wheelchair

☐ Stretcher ☐ Ambulance

☐ Oxygen ☐ Drip

☐ Forklift ☐ Humidicrib

☐ Other ►

5. Is an Escort or accommodation required?

☐ No

☐ Yes

Reason

Escorts are only approved on medical grounds, (eg. patient requires oxygen, sedation, parental analgesia) or for dependent children under the age of 17.

6. Name of recommended Escort

DECLARATION

I certify that the information in Form D2 is correct and has been completed by me.

I give my permission for the approving hospital's Medical Superintendent to contact me regarding my recommendation for the patient to return home.

Name (printed)

Signature of Specialist

Date

TREATING HOSPITAL FAX:

WHEN THIS FORM IS COMPLETE, THE PATIENT/GUARDIAN OR CARER SHOULD CONTACT THE APPROVING HOSPITAL (DETAILS AS PER FORM C2) OR THE TRAVEL OFFICE OF THE TREATING HOSPITAL.

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FORM D3 – ONGOING SPECIALIST TREATMENT

Specialist Completes

TO BE COMPLETED IF THE PATIENT REQUIRES ONGOING SPECIALIST TREATMENT.
ADDITIONAL INFORMATION CAN BE ATTACHED TO THIS FORM.

PATIENT DETAILS

1. Patient Details (or affix Patient label)

Name:
Date of Birth:
UR No.:
Address:

Telephone:

ONGOING TREATMENT RECOMMENDATION

2. Diagnosis/Nature of ongoing treatment

3. Is the treatment available in the patient's local area, or at a hospital/public health facility closer to where the Patient lives?

☐ No
☐ Yes

If Yes, please provide medical reasons for treatment to be considered:

Referrals to specialists that are not the nearest to a patient's place of residence is at the determination of the approving hospital's Medical Superintendent.

4. Will the Patient require In-patient treatment?

☐ No ▸ Go to Question 6
☐ Yes

5. Dates of continuing In-patient treatment

Date from	Date to

6. Will the Patient require Outpatient treatment?

☐ No ▸ Go to Question 8
☐ Yes

7. Dates of continuing Outpatient treatment

Date	Time (if known)

8. Will the Patient require special travel arrangements?

☐ No
☐ Yes

If Yes, please detail

ESCORT DETAILS

9. Is it necessary for medical reasons for an escort to accompany the Patient to provide critical support

a) While travelling?

☐ No
☐ Yes

b) During the Patient's hospitalisation?

☐ No
☐ Yes
☐ Not Applicable

c) During the Patient's outpatient treatment?

☐ No
☐ Yes
☐ Not Applicable

If Yes to any of the above questions, please provide details/reason

10. Name of recommended Escort

DECLARATION

I certify that the information in Form D3 is correct and has been completed by me.

I give my permission for the approving hospital's Medical Superintendent to contact me regarding the patient's ongoing treatment.

Name (printed)

Signature of Specialist

Date

TREATING HOSPITAL FAX: ☐

PATIENT TRAVEL SUBSIDY SCHEME (PTSS)

FORM E – PATIENT DECLARATION

Patient/Guardian or Carer Completes

IN ORDER TO ENSURE REIMBURSEMENT OF ANY FUNDS THROUGH THE SCHEME OR PAYMENT TO OTHERS, THIS FORM MUST BE SUBMITTED TO THE PATIENT'S NEAREST PUBLIC HOSPITAL AS SOON AS POSSIBLE AFTER THE COMPLETION OF TREATMENT.

RELEVANT RECEIPTS AND TAX INVOICES MUST ALSO BE ATTACHED.

PATIENT DETAILS

1. **Name**

TRAVEL DETAILS

2. **Did you travel by a private motor vehicle?**
   - ☐ No ▸ Go to Question 4
   - ☐ Yes

3. **Nearest public hospital to Patient's residence?**

   Approved Private Motor Vehicle allowance is calculated at 15 cents per kilometre from the post office of the centre of the approving hospital to the post office of the centre of the treating hospital.

4. **Are travel receipts attached?**
   - ☐ No
   - ☐ Yes
   - ☐ Not Applicable

   Patients/Guardians or Carers who have purchased their own tickets for travel between their home and the treating facility are to attach receipts. The full fare will not necessarily be refunded, rather a subsidy will be paid based upon travel costs which the approving hospital would have incurred, had that hospital purchased the tickets prior to the journey.

ACCOMMODATION DETAILS

5. **Are accommodation tax invoices and receipts or the Private Accommodation Confirmation Form attached?**
   - ☐ No
   - ☐ Yes
   - ☐ Not Applicable

   If you do not have accommodation tax invoices/receipts it will be necessary for you to obtain duplicate tax invoices/receipts. Tax invoices/receipts should include the names of the person(s) accommodated, the dates, and the cost.

DECLARATION

I declare that the above information is correct, that the expenditure claimed was actually incurred and that benefits relating to that expenditure have not been received or claimed
(1) under any Commonwealth, State or Territory Scheme;
(2) from a registered medical benefits organisation; or
(3) in respect of any claim for Third Party Worker's Compensation, etc.

I hereby authorise Queensland Health to recover any payments from:

(alternative source, eg. Veterans' Affairs, Insurance Company Name, etc) for this journey.

I hereby authorise travel payment to be made to (please PRINT):

Name

Address

City/Town

Postcode

I hereby authorise accommodation payment to be made to (please PRINT):

Name

Address

City/Town

Postcode

Signature of Patient/Guardian or Carer

Name (printed)

Signature of Patient/Guardian or Carer

Date