WA Country Health Service
Department of **Primary Industries and Regional Development**
GOVERNMENT OF WESTERN AUSTRALIA

Patient Assisted Travel Scheme (PATS)

Assistance in Advance Application

Form C1

☐ **Requesting financial assistance prior** to my trip, for my appointment on _____ (app date)

For ☐ accommodation ☐ travel, fuel card ☐ travel, bus/train/flight

Proof of your specialist appointment(s) required for assistance in advance (e.g. appointment letter, email, text message).

Title **Surname**

Given name (s) **Preferred name**

Address

Phone number and/or **Email address**

Date of birth

APPOINTMENT DETAILS *Eligibility criteria applies. Including but not limited to the nearest specialist including telehealth or visiting specialist.*

Appointment Date _____ **Hospital/Clinic Location** _____

Specialty _____ **Specialist Name** _____

within 30 days ☐ Yes, if within 10 days please also call your local PATS Office

for **cancer treatment** ☐ Yes, or **renal dialysis** ☐ Yes

for **radiology** ☐ MRI ☐ Mammogram ☐ CT Scan ☐ Ultrasound ☐ Nuc Med ☐ PET ☐ X Ray

If this travel related to Motor Vehicle Insurance or Workers Compensation eligibility criteria applies, please contact your local PATS Office.

TRAVEL & ACCOMMODATION DETAILS *Eligibility criteria applies.*

Transport ☐ Private vehicle ☐ Train ☐ Bus ☐ Air travel[1]

Departure Date _____ **Return Date** _____

Accommodation Preferred location (if available): _____

Recipient _____ to _____ ☐ Private[2] ☐ Commercial[3]

Recipient _____ to _____ ☐ In Hospital

Support Person _____ to _____ ☐ Private[2] ☐ Commercial[3]

Support Person for ☐ Cancer treatment ☐ Cultural/linguistic support ☐ Childbirth ☐ Disability ☐ Under 18 ☐ Other, please specify below

Support Person Name Phone Number

[1]Air travel eligibility; Trips over 1200km one way are automatically eligible for air travel or over 350km one way if travelling for cancer treatment. Trips under 1200km one way will require supporting clinical information for flights to be approved provided below.

[2]Private Accommodation is to stay with family/friends. [3]Commercial accommodation is to stay at hotel, motel, caravan park.

If required please use this space to provide additional information and/or attach any relevant medical documentation to support your claim:

(If known) Referring Practitioner Name _____

Practice Name Phone

Declaration (Recipient or Parent/Guardian) I declare that the information provided is true and correct, the requested expenditure will be incurred by me for the reasons outlined here and I am not entitled to claim or recover costs from any other source including compensation, insurance cover or damages. I accept liability for any obligation to pay fees associated with damages to property or stolen goods claimed by accommodation providers and understand that the WACHS may pursue debts associated with these fees. If I miss pre-booked travel or accommodation without a valid reason WACHS may pursue debts associated with these fees. I give consent for WACHS staff to obtain or distribute information from/to any third party necessary or this application or to deliver relevant health care.

Signature **Date**

OFFICE USE ONLY

PATS Clerk ☐ Approved ☐ Declined Reference # _____

Delegated Financial Authority ☐ Approved ☐ Declined Signature/ he # _____

Appointment proof via text message sighted ☐ Signature/ he # _____

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST

WA Country Health Service
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Patient Assisted Travel Scheme (PATS)

Assistance in Advance Verification of Attendance

Form C2

☐ I am **verifying attendance only**, I received assistance in advance prior to my trip.

If you require reimbursement for any accommodation/travel outside of the assistance in advance you have already received please complete the details in the box below "Is there any change" and provide any relevant receipts.

Title **Surname**

Given name (s)

Date of birth

APPOINTMENT DETAILS *Eligibility criteria applies. Including but not limited to the nearest specialist including telehealth or visiting specialist.*

Appointment Date _____ **Hospital/Clinic Location** _____

Speciality **Specialist Name**

Is there any change from your approved assistance in advance accommodation/travel method? Please provide details.

Recipient (or guardian) declaration and consent. I declare that the information provided is true and correct, the expenditure claimed was incurred by me for the reasons outlined in my assistance in advance application and I am not entitled to claim or recover costs from any other source including compensation, insurance cover or damages. I accept liability for any obligation to pay fees associated with damages to property or stolen goods claimed by accommodation providers and understand that the WACHS may pursue debts associated with these fees. I give consent for WACHS staff to obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care.

Signature **Date**

TO BE COMPLETED BY SPECIALIST OR CLINIC EMPLOYEE – For every appointment claim to verify claim.
To facilitate reimbursement of expenses and/or confirm travel details complete all sections.

Has the recipient's condition changed so they require air travel? ☐ Yes ☐ No ☐ N/A

Has the recipient's condition changed so they require a support person? ☐ Yes ☐ No ☐ N/A

Has the recipient's condition changed so they need to extend their stay? ☐ Yes ☐ No ☐ N/A

Was the recipient hospitalised? ☐ No ☐ Yes, from _____ to _____

If 'Yes' to any of the above, please provide clinical reason:

Can the follow up appointments be done via telehealth? ☐ Yes ☐ No

Stamp (required)

Signature _____

Name _____

Date

OFFICE USE ONLY

PATS Clerk ☐ Approved ☐ Declined Reference # _____

Delegated Financial Authority ☐ Approved ☐ Declined Signature/ he # _____

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