Government of Western Australia
WA Country Health Service

Patient Assisted Travel Scheme (PATS)

Form 1: Apply for PATS – Allied Health and Dental

Important information

- Complete this form to register or apply for PATS assistance. Please make sure you understand PATS eligibility and subsidies before you apply - *see PATS website for further information*.
- One form is required per trip. A trip is a return journey from your home.
- You **must** provide proof to support your application. Each section explains what you need to include.
- Your application may be delayed or declined if information or documents are missing.

SECTION A Patient and contact details

Title: _____ **Surname:** _____ **Sex:** _____

Given name(s): _____ **Date of birth:** ___/___/_____

Preferred name: _____ **URMN** *(if known)*:_____

Residential address: _____

Is the patient the main contact for this application? ☐ Yes ☐ No

If no, contact name: _____ Relation to patient: _____

Contact number: _____ **Email address:** _____

Has the patient applied to PATS in the last 12 months **AND** are their banking, Medicare and/or concession details the same?	☐ No / unsure – *complete Section B* ☐ Yes – *go to Section C*

SECTION B Register for PATS and/or update details

Does the patient identify as Aboriginal and/or Torres Strait Islander?		☐ Yes ☐ No ☐ Prefer not to say	
Medicare:	Card number: __ __ __ __ __ __ __ __ __ __ IRN: __ __ Expiry: __ __ / __ __ __ __		
Banking:	Account Name: _____ BSB: __ __ __ __ __ __ Account number: __ __ __ __ __ __ __ __ __		
Concession:	Does the patient have a Veteran Card?	☐ No	☐ Yes: *Gold / White*
	Does the patient have other concession card(s)? ☐ No ☐ Yes *If yes*, Type: _____ Card number: _ _ _ _ _ _ _ _ _ Expiry: _ _ / _ _ / _ _ _ _		
	Supporting documents:	☐ Photo Identification *(i.e. drivers license, passport)* ☐ Proof of residency that states applicant name and address	

SECTION C Reason for travel – *Tick all that apply*

☐ Allied Health ☐ Dental ☐ Cancer Treatment ☐ Renal Dialysis

☐ Surgery / procedure: _____ ☐ Other: _____

Radiology: ☐ MRI ☐ CT scan ☐ X-RAY ☐ Nuclear Medicine ☐ Mammogram ☐ PET Scan ☐ Ultrasound

Details	Date: __ __ / __ __ / __ __ __ __	Time: __ __ : __ __
	Hospital/ clinic name: _____	Location: _____
	Clinician name *(if known)*: _____	Specialty: _____
	Date: __ __ / __ __ / __ __ __ __	Time: __ __ : __ __
	Hospital/ clinic name: _____	Location: _____
	Clinician name *(if known)*: _____	Specialty: _____
	Supporting documents:	☐ Proof of each appointment/service (*i.e. appointment letter, receipt, PATS Form 2, discharge summary, email, text*)

To submit forms, provide feedback or talk to someone

Email: PATS.AHD@health.wa.gov.au *Call: 1800 944 016* *In person:* Regional PATS office

SECTION D	**I am requesting assistance for:** *(Tick all that apply)*	☐ a past trip *(Reimbursement)* ☐ an upcoming trip *(Assistance in Advance- AiA)*

☐ **Transport:** ☐ Private vehicle ☐ Bus ☐ Train ☐ Air travel

Departure date: __ __ / __ __ / __ __ __ __ Return date: __ __ / __ __ / __ __ __ __

☐ **Accommodation*:** ☐ Private ☐ Commercial

Check in date: __ __ / __ __ / __ __ __ __ Check out date: __ __ / __ __ / __ __ __ __

☐ **Support person**:** Reason: _____

Details: Title: _____ Surname: _____ Date of birth: ___/___/_____

Given name: _____ Contact number: _____

Requires: ☐ **Transport:** ☐ Private vehicle ☐ Bus ☐ Train ☐ Air travel

Departure date: __ __ / __ __ / __ __ __ __ Return date: __ __ / __ __ / __ __ __ __

☐ **Accommodation*:** ☐ Private ☐ Commercial

Check in date: __ __ / __ __ / __ __ __ __ Check out date: __ __ / __ __ / __ __ __ __

*Accommodation: 'Private' is to stay with family/friends, 'Commercial' is to stay at a hotel, motel, caravan park etc.
**Applications for Support Persons will be assessed against eligibility in the *PATS handbook*.

Supporting documents: *If applicable*	☐ Receipts for accommodation/Travel (*bus, train, air only*) ☐ Evidence of support person requirement (*i.e. PATS Form 2- with section C completed, letter from clinician*)

OTHER INFORMATION	If required, use this section to add any extra details to support the application

DECLARATIONS

Is this trip related to a motor vehicle accident, workers compensation, Employer-funded travel claim?	☐ No ☐ Yes – a signed *Statutory Declaration is required*

- I declare that the information I have provided in this form is true and correct.
- I understand that:
  - Giving false or misleading information is a serious offence.
  - Neither the WA Country Health Service (WACHS) nor the Department of Primary Industry and Regional Development (DPIRD) are responsible for damages, payments, losses or fees/charges that I may incur due to me providing incorrect banking details in this form.
  - I am not entitled to claim or recover the costs claimed from any other source including compensation, insurance cover or damages.
  - I accept liability for any obligation in incurred by WACHS to pay all costs associated with damage to property, stolen goods or no-shows in connection with accommodation booked by WACHS pursuant to this form and understand that WACHS may pursue recovery action from me in relation to such costs
- I consent to:
  - WACHS and DPIRD collecting and handling personal information in this form for the purposes of administering and processing my applications, claims and payments under PATS.
  - WACHS and DPIRD contacting and sharing my information with my health care, transport or accommodation provider(s) for the purpose of processing and administering this claim.
  - My health care, transport or accommodation provider(s) disclosing information about me to WACHS and DPIRD for the purpose of processing and validating this claim, and to WACHS and DPIRD showing them this signed consent.

For Assistance in Advance requests ONLY:

- I understand that my future subsidies may be affected if I miss my travel and/or accommodation booking(s) without a valid reason.

Name: _____ **Signature:** _____ **Date:** __ __ / __ __ / __ __ __ __

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