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

Submit your completed form to your local PATS office

☐ **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 ☐ No

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 ◯ Bus ◯ Train ◯ Air travel[1]

Departure Date _____ **Return Date** _____

Accommodation

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

Recipient _____ to _____ ☐ In Hospital

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

Support Person for ☐ Childbirth ☐ Cultural/linguistic support ☐ Cancer treatment ☐ Disability ☐ Under 18

Other, please specify _____

Support Person Name _____ Phone Number _____

[1]Air travel eligibility; Photo ID is required for flights. 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 at a hotel, motel, caravan park or to pay. Please include Accommodation provider details below if you have booked your Accommodation and need a purchase order be sent.

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

Submit your completed form to your local PATS office

☐ 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
Can the follow up appointments be done via telehealth?	◯ Yes	◯ No	◯ N/A

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

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

Stamp (required)

Signature _____

Name _____ Date _____

OFFICE USE ONLY

PATS Clerk ☐ Approved ☐ Declined Reference # _____

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

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Clear Form