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

Patient Assisted Travel Scheme (PATS)

Registration and Recipient Details Form A

Submit your completed form to your local PATS office

◯ I am **applying for PATS** for the first time, or ◯ a current PATS recipient **updating my details**

REQUIRED if completing Form A

Title _____ **Date of birth** _____ **Sex** _____

Surname _____

Given name (s) _____

Preferred name _____

Email address _____
and/or
Phone number _____

Person under 18 parent or guardian
Name _____
Phone _____

Permanent residential address

If registering for first time or updating residential address, please attach proof of address via one of the following: drivers license, health care card, current lease agreement or utility bill for gas, internet or electricity that states applicant name and supply address.

Postal address if different from above

Do you identify as Aboriginal and/or Torres Strait Islander?
◯ Aboriginal ◯ Torres Strait Islander ◯ Aboriginal & Torres Strait Islander ◯ Prefer not to say ◯ Neither

REQUIRED if completing Form A and registering for first time or if details have changed since last application

Medicare
Card Number _____
Individual reference number _____ Expiry Date _____

Veteran Affairs
DVA card holders should contact DVA in the first instance ◯ White ◯ Gold
Card Number _____ Expiry Date _____

Pensioner or concession
Card Number _____
Type _____ Expiry Date _____

Bank Account Details
Account Name _____
6 Digit BSB No _____ Account No _____

Recipient Declaration (or Parent/Guardian) I declare that the information provided is true and correct. I confirm that PATS is not responsible for payment losses or fee/charges that may be incurred if incorrect banking details are provided.

Signature: _____ **Date:** _____

Privacy: WA Country Health Service (WACHS) will review and confirm the details you provide to assess your PATS requests. Your information is stored within a secure system. WACHS staff may obtain or distribute information from/to any third party necessary for this application or to deliver relevant health care. Further information is provided in the Department of Health Privacy Statement.

OFFICE USE ONLY ☐ Sighted proof of residency PATS Clerk signature / he # _____

THIS FORM IS AVAILABLE IN AN ALTERNATIVE FORMAT ON REQUEST

Clear Form