Patient Travel Subsidy Scheme (PTSS)
APPLICATION FORM

PTSS ID Number:	PTSS Claim Number:	PTSS Application Number:

The PTSS provides assistance to eligible patients who need to access essential PTSS-approved specialist medical services which are not available within their local area. The PTSS may also provide a subsidy to assist an escort or guardian to accompany the patient. **Further information is available from** www.health.qld.gov.au/ptss

PTSS applications must be submitted to the patient's nearest public hospital for assessment PRIOR to travel.

SECTION A – PATIENT INFORMATION *(to be completed by the patient or guardian)*

Title:	Family name:	Residential address:
Given name(s):		
Date of birth:		Postal address *(if different to above)*:
Mobile phone:		
Home phone:		Email address:

1. Have you received a PTSS accommodation subsidy within the last financial year (1 July to 30 June)? ..... ☐ Yes ☐ No
2. Are you accessing treatment as a private patient or through private health cover?..... ☐ Yes ☐ No

3. Do you hold the following cards?

☐ **Medicare** *Expiry Date*

☐ **Dept of Veterans Affairs** ☐ Gold ☐ White *Expiry Date*

☐ **Health Care Card** *Expiry Date*

☐ **Pensioner Concession Card** *Expiry Date*

☐ **Commonwealth Seniors Health Card** *Expiry Date*

4. **Indigenous status:**
   - ☐ Aboriginal but not Torres Strait Islander origin
   - ☐ Torres Strait Islander but not Aboriginal origin
   - ☐ Both Aboriginal and Torres Strait Islander origin
   - ☐ Neither Aboriginal nor Torres Strait Islander origin
   - ☐ Not stated/inadequately described

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

6. Have you lodged or do you intend to lodge a third party or Workers Compensation Claim relating to this treatment?
   ☐ Yes ☐ No

Patient Declaration:

The information that I have provided is true and accurate at the time of application. I give my permission for hospital staff to obtain information about my medical condition for the purposes of this application and provide to the treating facility as required. I give permission for hospital staff to forward transport and accommodation details to relevant providers as is required. I consent for the subsidy to be provided directly to my transport and/or accommodation provider under a bulk-billing arrangement if available. I certify that any subsidies provided to me will be used for the purposes of travelling to access the stated specialist service.

Signature of Patient or Guardian	Name of Patient or Guardian (please print)	Date

PLEASE NOTE: Patients who have not received PTSS subsidies previously, or whose details have changed, are required to complete a vendor set up form available at www.health.qld.gov.au/ptss or from your local hospital.

Please complete Section C 'Appointment Details' on pg. 2 if Specialist appointment details are known.

Queensland Government

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SECTION B – REFERRAL *(to be completed by referring clinician)*

Patient Name:		Date of birth:
Reason for travel: ☐ Diagnosis ☐ Treatment ☐ Review	Specialty Type:	
Current diagnosis and procedure required:		
Specialist Name/Location:		
Is this the nearest specialist? ☐ Yes ☐ No►	*If No, why?*	

Recommended mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private motor vehicle ☐ Other *(provide details)*:			
Clinical reason for travel mode:			
Does the patient have any special travel requirements? ☐ Stretcher ☐ Wheelchair ☐ Oxygen ☐ Other:			
Does the patient require accommodation? ☐ Yes ☐ No	From:	To:	
Reason for patient accommodation:			

Is an escort required to provide support to the patient? ☐ Yes *(If yes, provide **clinical** reason for escort below)* ☐ No			
Title:	Escort name:		Phone:
Does the escort require accommodation? ☐ Yes ☐ No	From:	To:	
Reason for escort accommodation:			

Declaration by Referring Doctor

I certify that the information in Section B is correct. I give permission for HHS staff to contact the referring facility regarding this application.

Name:	**Provider stamp:**
Provider number:	
Signature:	
Date:	

SECTION C – APPOINTMENT DETAILS *(may be completed by patient, referring doctor or approving hospital)*

IF COMPLETED BY PATIENT, EVIDENCE OF APPOINTMENT MUST BE PROVIDED e.g. Confirmation letter or card

Appointment date:	Appointment time:
Patient status at treating facility: ☐ Public ☐ Private	

SECTION D – ASSESSMENT & APPROVAL *(to be completed by approving officer – admin use only)*

Has Telehealth been assessed as an alternative to travel for this application? ☐ Yes *(reasons for approval below)* ☐ No *(provide reasons):*

☐ PTSS Approved **PTSS ID No.:** **PTSS Claim No.:** **Patient Vendor No.:**

PTSS Approved for initial trip only: ☐	PTSS Approved for / /	to: / /	
Approved patient mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private Motor Vehicle ☐ Other			
Approved escort mode of travel: ☐ Bus ☐ Rail ☐ Air ☐ Private Motor Vehicle ☐ Other			
Is Patient Accommodation approved? ☐ Yes ☐ No	From:	To:	
Is Escort Accommodation approved? ☐ Yes ☐ No	From:	To:	
Name of PTSS Approver (or delegate):		*I authorise this travel/accommodation as medically required*	
Signature:		Date:	
Name of financial delegate:		*I authorise expenditure incurred for this application*	
Signature:		Date:	

☐ PTSS Not Approved *Provide reasons for non-approval* ►