NSW GOVERNMENT Health

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

Form 1: Application for travel and accommodation assistance

Use our online services

You can apply online. This means you do not have to complete this paper form. You can register to use our online services at **iptaas.enable.health.nsw.gov.au**

When to use this form

You require a separate application for each different practitioner or health service you travel to.

You should use this form if:

- this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service
- you have not submitted a referral for this practitioner or health service in the last **two years**
- your personal details have changed since the last time you submitted an application and you have not updated them using our online services

What else you may need to provide

We may require documentation to support your application. You may need to provide:

- invoices for travel and accommodation costs
- evidence that you have attended your appointment

Filling in this form

- please use black or blue pen
- print in BLOCK LETTERS
- mark boxes like this ☐ with a ✓or ✕
- where you see a box like this ☐ ***Go to question…*** skip to the question number shown. You do not need to answer the questions in between.

For more information

Go to our website **www.iptaas.health.nsw.gov.au** or call us on **1800 IPTAAS** (**1800 478 227**).

Applications must be submitted within 12 months of your discharge or appointment end date.

Part A. Eligibility details

Please read before answering question 1.

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS. If you are receiving assistance from another government or third party service do not complete this form.

1. Have you received, or are you eligible for financial assistance for travel and accommodation from

An Australian federal, state or territory government travel scheme, other than IPTAAS?	☐ No	☐ Yes
Department of veterans' affairs?	☐ No	☐ Yes
Workers compensation?	☐ No	☐ Yes
Motor vehicle insurance?	☐ No	☐ Yes

Part B. Patient details

2. Patient ID (if known)

3. Your name Title | Given name | Middle name | Surname

4. Your date of birth D D/M M/Y Y Y Y

5. Your gender ☐ Male ☐ Female ☐ Other

6. Your Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Line no. ☐

7. Do you have a concession card issued by Centrelink or DVA?

☐ No ***Go to question 8***

☐ Yes Give details Concession card number Concession card expiry date D D/M M/Y Y Y Y

8. Your residential address

State Postcode

9. Your postal address (if different to residential)

State Postcode

10. Your contact details Email | Phone number ( ) | Mobile number

What is your preferred contact method? ☐ Post ☐ Email ☐ Phone ☐ Mobile

11. Are you of Aboriginal or Torres Strait Islander Australian descent? ☐ No ☐ Yes

12. Your authorised contact (optional) Name | Relationship to you

Phone number ( ) | Mobile number

Part C. Referral details

Please read before completing Part C. Referral details.

Part C: Referral details is only required if this is the first time you have applied for assistance from IPTAAS to travel to this practitioner or health service, or you have not submitted a referral to this practitioner or health service in the last two years.

If required, **Part C: Referral details** is to be completed by your referring practitioner or their authorised representative.

13. Referring practitioner details Full name | Phone number ( )

14. Treatment details

Name of practitioner or health service you referred the patient to

Treatment location | Type of treatment referred for

Is the practitioner or health service the nearest to the patient's residence?

☐ Yes ***Go to question 15***

☐ No Give details below

Why was the patient not referred to the nearest practitioner or health service?

15. Referring practitioner declaration (to be completed by the referring practitioner or their authorised representative)

Name | Position

I declare that:

- the information provided in Part C of this form is complete and correct

I understand that:

- giving false or misleading information is an offence

Signature Date D D/M M/Y Y Y Y

Part D. Air travel details

Please read before answering question 16.

If you need to travel by commercial air, you should get an air approval. Your practitioner or their authorised representative must contact IPTAAS to get an air approval. You will only get an air approval if you meet the air approval criteria.

16. What is your air approval code?

Part E. Treatment details

17. What type of treatment did you travel for? (Select one and answer applicable questions)

☐ **Specialist**

Was your treatment part of a clinical trial? ☐ No ☐ Yes

Was your travel for health screening? ☐ No ☐ Yes

☐ **Allied Health**

☐ **Dental**

Do you have a cleft palate? ☐ No ☐ Yes

Did you have surgery under general anesthesia? ☐ No ☐ Yes

☐ **Prosthetic/Orthotic**

Did you travel to a public hospital or public clinic? ☐ No ☐ Yes

18. Treatment details

Name of specialist, allied health clinic, dentist or prosthetist/orthotist

Phone number ( )

Medicare provider number (not applicable to allied health or prosthetic/orthotic treatment)

OPTIONAL: AHPRA registration number (if known) (not applicable to allied health or prosthetic/orthotic treatment)

Treatment address

State Postcode

19. Were you hospitalised?

☐ Yes Give details

Admission date D D/M M/Y Y Y Y

Discharge date D D/M M/Y Y Y Y

☐ No If no, what was your appointment date?

Start date D D/M M/Y Y Y Y

End date (if different to start) D D/M M/Y Y Y Y

20. Did you need to stay before or after the hospitalisation or appointment dates?

☐ No ***Go to question 21***

☐ Yes Give details ☐ **nights before** and/or ☐ **nights after**

Please read before completing question 21.

Question 21: Practitioner or health service declaration is optional unless you are staying more than two nights before or after your appointment/hospitalisation dates.

If completed, **Question 21: Practitioner or health service declaration** is to be completed by your treating practitioner or health service, or their authorised representative.

21. Practitioner or health service declaration (to be completed by the treating practitioner, health service or their authorised representative)

Name

Position

I declare that:

- the information provided in Part E of this form is complete and correct

I understand that:

- giving false or misleading information is an offence

Signature

Date D D/M M/Y Y Y Y

Part F. Payment details

22. Your bank account details

Account name

BSB number ☐☐☐ ☐☐☐

Account number ☐☐☐☐☐☐☐☐☐

23. Would you like a third party organisation to receive part of your subsidy?

☐ No ***Go to question 24***

☐ Yes Give details below

What part of your subsidy would you like the third party organisation to receive? ☐ Travel ☐ Accommodation ☐ Both

Third party organisation details

Name

Phone number ( )

ABN ☐☐ ☐☐☐ ☐☐☐ ☐☐☐

Supplier number (if known)

Part G. Travel and accommodation details

Please read before completing Part G. Travel and accommodation details.

This form is for **one trip** from your residence to the health service and return. If you would like to claim in transit travel or travel and/or accommodation for more than one trip you should complete and attach **Form 2. Travel and accommodation supplement** to this application.

You need to provide invoices for travel and accommodation costs (except private vehicle travel and private accommodation) with your application.

24. Were you accompanied by an escort during travel or accommodation?

☐ No ***Go to question 26***

☐ Yes Give details Your escort's full name

25. Does your escort have a concession card issued by Centrelink or DVA?

☐ No ***Go to question 26***

☐ Yes Give details Your escort's concession card number Your escort's concession card expiry date D D/M M/Y Y Y Y

26. Your travel details

Travel dates Departure date D D/M M/Y Y Y Y Return date D D/M M/Y Y Y Y

Mode of travel (Check applicable box)	Forward Patient	Escort	Return Patient	Escort
Private vehicle	☐	☐	☐	☐
Public transport	☐	☐	☐	☐
Commercial air	☐	☐	☐	☐
Community transport	☐	☐	☐	☐
Emergency transport	☐	☐	☐	☐
Taxi	☐	☐	☐	☐

27. Are you claiming accommodation?

☐ No ***Go to question 29***

☐ Yes Give details Check in date D D/M M/Y Y Y Y Check out date D D/M M/Y Y Y Y

28. What type of accommodation did you stay in?

More information about accommodation types is available on our website. ☐ Private ☐ For Profit ☐ Not for profit

Part H. Patient declaration and privacy

The information contained in this application is protected by law from unauthorised access and misuse. The information will only be accessed by health service staff directly involved in providing services to the applicant, or with other lawful excuse. You can view our privacy statement on our website.

29. Patient declaration (to be completed by you or your parent, guardian, escort or authorised contact)

I declare that:

- The information I have provided in this form is complete and correct and the documents provided are genuine
- If applicable, I am authorised to complete this application on behalf of the patient

I understand that:

- NSW Health may make relevant enquiries to assess this application and make sure I receive the correct subsidy
- I may be audited. If my practitioner or health service did not complete question 21 of this form I am required to keep evidence to prove I attended my appointment for **two years**
- Giving false or misleading information is an offence

Your name

Your signature Date D D/M M/Y Y Y Y

Submitting your form

Check that all required questions are answered and that the form is signed and dated. You can submit this form and supporting documentation to your local IPTAAS office by email, post or fax. Please ensure forms submitted by post are addressed to IPTAAS.

Hunter New England – Tamworth

Post: Locked Bag 9783, Tamworth NEMSC NSW 2348

Email: HNELHD-IPTAAS@health.nsw.gov.au

Fax: (02) 6766 4576

Northern NSW, Mid North Coast – Port Macquarie

Post: PO Box 126, Port Macquarie NSW 2444

Email: MNCLHD-TFH-IPTAAS@health.nsw.gov.au

Fax: (02) 5524 2996

Far West – Broken Hill

Post: PO Box 457, Broken Hill NSW 2880

Email: FWLHD-IPTAAS@health.nsw.gov.au

Fax: (08) 8080 1695

All other

Post: Locked Bag 5270, Parramatta NSW 2124

Email: IPTAAS@health.nsw.gov.au

You may be able to provide your form in person at one of our offices. Contact IPTAAS for more information about over the counter services.