

### **NSW Health**

# Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

# Form 6. Application For Travel And Accommodation Assistance For Donors

#### There are two ways to apply to IPTAAS

Apply online at **iptaas.enable.health.nsw.gov.au. OR** Complete this form

#### When to use this form

You should use this form if:

• you donated an organ or tissue to an NSW resident.

Do not use this form if:

- the person you donated to is not an NSW resident
- you are a transplant recipient

NSW transplant recipients should complete Form 1. Travel and

**Accommodation Claims** 

#### When using this form

**Part C:** if the patient is medically required to fly to their appointment or treatment, the referring health professional, medical practitioner, health service or authorised representative must call and obtain an air approval code before they fly. This will ensure they are paid at the correct rate.

**Part D:** If the patient needs to stay two or more nights before or after the appointment/treatment dates, the medical practitioner or health service must complete this section.

If you need help, call our team on **1800 478 227** or send an email to **iptaas@health.nsw.gov.au** 

All claims must be submitted within 12 months of the patient's discharge or appointment end date.

#### Part A. Eligibility details

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS.							
1.		or are they eligible for financial assistance fo	r travel and accon	nmodation fr	om (these should not		
	include IPTAAS):						
		state or territory government travel scheme?	□ No □ Yes				
	Department of veterans' aff	fairs (DVA)?	☐ No ☐ Yes				
	Workers compensation?		☐ No ☐ Yes				
	Motor vehicle insurance?		□ No □ Yes	3			
2.		organ or tissue to a NSW resident?					
	No Stop They are not eligible for assistance from IPTAAS. You should contact the recipient's relevant state or territory travel scheme.						
	$\square$ Yes Give details below						
	Recipient full name						
	Recipient residential						
	address			State	Postcode		
Part B. Donor details							
3.	Patient name	Title Given name Middle r	name	Surname			
4.	Patient date of birth	D D/M M/Y Y Y Y					
5.	Patient gender	☐ Male ☐ Female ☐ Prefer	not to say				
6.	Patient Medicare card number Line no.						
7.	Patient residential address						
				State	Postcode		
				Otato	1 0010000		
8.	Patient postal address						
	(if different to residential)			State	Postcode		
9.	Patient contact details	Email	Phone number	М	obile number		
			( )				
10. What is the preferred contact method? Post Email Phone Mobile							
11. Does the patient identify as Aboriginal and or Torres Strait Islander?							
	12. Patient authorised contact Name Relationship to patient						
	(optional)		Trotation	o.np to patio			
		Phone number Mobile number					
		/ \					

#### Part C. Air approval code

If the patient is medically required to travel by commercial air, the practitioner or authorised representative is to call 1800 478 227 to obtain an air approval code prior to flying. If this is not obtained, claims will be paid at the private car rate. 13. What is the air approval code? Part D. Treatment details 14. Treatment details Name of specialist Phone number Medicare provider number Treatment address Postcode State 15. Was the patient hospitalised? Yes Give details Admission date Discharge date ☐ No End date (if different to start) If no, what was the appointment date? Start date Part E. Travel and accommodation details 16. Did someone travel or stay with the patient? (this may also be referred to as an escort. This can include a spouse, carer, partner, or parent) ☐ Yes → Give details The escort's full name Travel mode: People travelling: Trip type: Accommodation Type Private vehicle-PV Community transport - CT Patient only - P One way - O Private accommodation - Priv Emergency transport - ET Taxi - TX Public transport-PT Escort only - E Return - R Paid accommodation - Paid Commercial air - AIR Patient and escort - PE **Travel dates** Travel dates Travel People Trip Address Hospitalisation Accommodation Appointment date Acc travelling mode type dates Type dates (if applicable) (if applicable) Start / From Start date Admission / Check in End date Check out Discharge End To Start / From Start date / Admission / / Check in End date Check out End To Discharge Start date Check in Start / From Admission / End То End date Discharge Check out Start / From Start date Admission / Check in End То End date Discharge Check out Provide any receipts for air, train, or taxi travel (including ride sharing such as uber.) Petrol receipts do not need to be provided. Receipts are not needed for stays in a private home. Do you have more trips to claim? Use From 2 Additional Travel and Accommodation Claims to submit additional trips. This can be found on the IPTAAS website. 17. Did the patient need to stay before or after the appointment or hospitalisation dates? ∟ No \_\_ Yes nights before and/or nights after The medical practitioner or health service must sign the declaration below if the patient stayed more than two nights before or after their appointment or hospitalisation dates listed on question 16. Otherwise, this is optional and you may be audited for evidence confirming information at a later date. 18. Medical practitioner or health service declaration I confirm: The information in part E is correct including appointment, hospitalisation and accommodation dates. Full name of authorising person Position I understand that: Giving false or misleading information is an offence Signature Date

#### Part F. Payment Details

Please provide the bank details where the subsidy is to be paid. If the subsidy is to be paid direct to a third party organisation, please provide their details in question 20.

please provide their details in question 20.		
19. Details of nominated bank account		
Account name BSB	number	Account number
20. Should part of the patients subsidy be received by a third party organisat	tion?	
□ No		
Yes Give details below		
What part of the subsidy would you like the third party organisation to receive	ive? 🗌 Travel	☐ Accommodation ☐ Both
Third party organisation details		
Name		Phone number
ABN		Supplier number (if known)
Part G. Donor declaration and privacy		
The information contained in this application is protected by law from unauthobe accessed by health service staff directly involved in providing services to tiview our privacy statement on our website.		
21. Patient declaration (to be completed by the patient, parent, guardian, esc	cort or authorised co	ontact)
I declare that:		
The information I have provided in this form is complete and correct and	I the documents prov	rided are genuine
<ul> <li>If applicable, I am authorised to complete this application on behalf of the</li> </ul>	he patient	
I understand that:		
<ul> <li>NSW Health may make relevant enquiries to assess this application and</li> </ul>	make sure I receive	the correct subsidy
<ul> <li>I may be audited. If my practitioner or health service did not complete quevidence to prove I attended my appointment for two years</li> </ul>	uestion 18 of this forr	m I am required to keep

### Giving false or misleading information is an offence

Name of person completing this form

Signature Date DD/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.

#### Far West - Broken Hill

Call: 1800 478 227 option 3 – Office operating hours

Monday-Friday 9am-4.00pm

Post: PO Box 457, Broken Hill NSW 2880 Email: FWLHD-IPTAAS@health.nsw.gov.au

**Fax:** (08) 8080 1695 **Location:** Broken Hill Hospital

## For all other areas, please send your completed application by post or email.

Call: 1800 478 227 option 4 – Office operating hours,

Monday-Friday 9am-5pm

**Post:** Locked Bag 5270, Parramatta NSW 2124

Email: IPTAAS@health.nsw.gov.au

**Location:** Over the counter assistance is also available in

Dubbo at the Dubbo Base Hospital

#### **Hunter New England - Tamworth**

Call: 1800 478 227 option 1 – Office operating hours

Monday-Friday 9am-4.30pm

Post: Locked Bag 9783, Tamworth NEMSC NSW 2348

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

Fax: (02) 6766 4576 Location: Tamworth Hospital

#### Northern NSW, Mid North Coast - Port Macquarie

Call: 1800 478 227 option 2 – Office operating hours

Monday-Friday 9am-4.30pm

Post: PO Box 126, Port Macquarie NSW 2444

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

**Fax:** (02) 5524 2996

Location: Port Macquarie Community Health Morton Street,

Port Macquarie