Patient Travel Subsidy Scheme (PTSS)

**Accommodation confirmation** (Form D)

**Section A - Patient details (HHS to complete)**

# Title Given name(s) Family name Identification number

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**Section B - Accommodation details (HHS or accommodation provider to complete)**

Commercial accommodation Private accommodation

Accommodation facility name (if commercial accommodation) Contact person

# Contact number Fax number Email address

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Did the patient and / or escort stay a different number of nights than were approved? Yes No If yes, provide details

I declare that the number of nights claimed are a true reflection of the actual nights stayed by the approved patient and / or patient escort(s).

Accommodation provider signature Date (DD / MM / YY)

|  |  |  |  |
| --- | --- | --- | --- |
| **Section C - Approved patient / patient escort details (HHS to complete)** | | | |
|  | Approved patient details | | Approved patient escort details |
| Given name(s) |  | |  |
| Family name |  | |  |
| Best contact number |  | |  |
| Check-in date (DD / MM / YY) |  | |  |
| Check-out date (DD / MM / YY) |  | |  |
| Total number of nights subsidised |  | |  |
| **Total subsidy approved for reimbursement** | |  |  |

**Section D - Approving hospital details (HHS to complete)**

# Hospital name

Contact person Contact number Fax number Email address

**Section E - Patient declaration (patient / guardian / patient escort to complete)**

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| --- | --- | --- |
|  |  |  |

I confirm that I stayed in the accommodation over the period approved above. I agree for any accommodation subsidy for which I have been approved to be paid directly to the accommodation facility. I am aware that I am liable at checkout for the full cost of any additional accommodation not previously approved by my closest public hospital or health facility.

# Patient (if 18 years or over) or Guardian / Carer Signature Date (DD / MM / YY)

Patient escort signature Date (DD / MM / YY)

**Hospital and Health Service use only**

*I, as the medical superintendent (or representative), authorise the above accommodation as required.*

Approver name Approver signature Date (DD / MM / YY)

**Queensland Health**

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