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| Patient Travel Subsidy Scheme (PTSS)Accommodation attendance (Form D) |
| **Section A – Patient details (HHS to complete)** |
| Title: | Given name(s):      | Family name:      | Identification number:      |
|  |
| **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:      |
| Did the patient and / or escort stay a different number of nights than were approved? [ ]  Yes [ ]  NoIf *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)** |
| *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):      |
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|    |
| **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): |