|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  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)** | | | | | | | | | | | | | | |
| *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): | | | |