NSW Health

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
Form 6. Voluntary assisted dying

When using this form
You should only submit this form when applying to IPTAAS for voluntary assisted dying related appointments.

Eligibility
To be eligible for assistance from IPTAAS for voluntary assisted dying, a patient must:

- Be a resident of New South Wales (NSW) or Lord Howe Island.
- Be enrolled with Medicare.
- Not be receiving, or eligible for, financial assistance for travel and accommodation from third party insurance or other Australian State and Territory government services.
- Travelling from their residence at least 100 km (one way).

Financial Assistance
Travel and accommodation assistance is available for eligible journeys for your appointments. Assistance is provided for the patient and one accompanying adult as an escort. A patient is eligible for two escorts if they are an Aboriginal or Torres Strait Islander person.

Visit IPTAAS website for a list of travel and accommodation subsidy rates.

Please note assistance is not available to cover the costs of meals and incidental expenses such as road tolls, parking and booking fees.

For more information call the IPTAAS team on 1800 478 227 or email HSNSW-vadassistance@health.nsw.gov.au

Part A. Eligibility details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

Patients receiving financial assistance for travel and accommodation from other services are not eligible for IPTAAS. If receiving other assistance, contact the IPTAAS team to confirm eligibility.

1. Has the patient received, or are they eligible for financial assistance for travel and accommodation from the following, not including IPTAAS (select if any apply):

☐ Another Australian federal, state or territory government travel scheme
☐ Department of Veterans' Affairs (DVA)
☐ Workers compensation
☐ Motor vehicle insurance

Part B. Patient details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

2. Patient name Title | First name | Middle name | Surname

3. Patient date of birth (dd/mm/yyyy)

4. Patient gender ◯ Male ◯ Female ◯ Non-binary ◯ Other

5. Patient Medicare card number Individual Reference Number *(number to the left of the name on the card)*

6. Patient contact details Phone | Mobile | Email

What is the preferred contact method? ◯ Post ◯ Email ◯ Phone ◯ Mobile

7. Patient residential address State | Postcode

8. Patient postal address (if different to residential) State | Postcode

9. Does the patient identify as Aboriginal and/or Torres Strait Islander? ◯ No ◯ Yes

10. Preferred language (if not English) ◯ Arabic ◯ Cantonese ◯ Filipino/Tagalog ◯ Greek ◯ Hindi ◯ Italian ◯ Mandarin ◯ Punjabi ◯ Spanish ◯ Vietnamese ◯ Other

11. Patient authorised contact (optional) Full name | Relationship to patient | Phone number inc. area code | Mobile number

Part C. Coordinating, consulting or administrative practitioner details

12. Full name Location

Part D. Travel and accommodation details (to be filled in by the patient, parent, guardian, escort or authorised contact)

Travel mode	**People travelling:**	**Trip type:**	**Accommodation type:**
• Private vehicle - PV • Public transport - PT • Commercial air - AIR • Community transport - CT • Emergency transport - ET • Taxi - TX	• Patient only - P • Escort only - E • Patient and escort - PE	• One way - O • Return - R	• Private accommodation (staying with family, friends or in AirBNB) • Paid accommodation • Bulk Billing (accommodation that is to be paid to a third party organisation)

13. Travel dates (provide dates in dd/mm/yyyy format)

Travel dates	**Travel mode**	**People travelling**	**Trip type**	**Address**	**Appointment date**	**Hospitalisation dates (if applicable)**	**Accommodation dates (if applicable)**	**Accommodation type**
Travel 1 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 2 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 3 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 4 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 5 Start End				From To	Start End	Admission Discharge	Check in Check out	

Travel dates	Travel mode	People travelling	Trip type	Address	Appointment date	Hospitalisation dates (if applicable)	Accommodation dates (if applicable)	Accommodation type
Travel 6 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 7 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 8 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 9 Start End				From To	Start End	Admission Discharge	Check in Check out	
Travel 10 Start End				From To	Start End	Admission Discharge	Check in Check out	

Attach receipts for accommodation, air, train, bus, or taxi travel including Uber. Petrol receipts do not need to be provided. Receipts are not needed for stays in a private home.

Part E. Payment details (to be filled in by the patient, parent, guardian, escort, or authorised contact)

Provide bank details for subsidy payment.

14. Details of nominated bank account

Account name

BSB number

Account number

Part F. Declaration and privacy (to be filled in by the patient, parent, guardian, escort, or authorised contact)

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.

The application may be audited to confirm the evidence and the information listed on the form. Patient's may be asked to provide evidence in the form of a Medicare benefit statement, a medical certificate or hospital discharge papers, an appointment schedule or written confirmation from the specialist or health service.

15. Patient declaration

☐ **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 confirm** that I am authorised to provide the personal details presented and I consent to my information being checked with the document issuer or official record holder via third party systems for the purpose of confirming my identity.

☐ **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 and I am required to keep evidence to prove I attended my appointment for two years.
- Giving false or misleading information is an offence.

By signing this document, I agree with the above declaration and privacy statement. Name of person completing this form:

Sign by typing in your name

Date (dd/mm/yyyy)

Submitting this form
Check that all required questions are answered and that the form is signed and dated. Return this form and supporting documentation to HSNSW-vadassistance@health.nsw.gov.au or mail it to Locked Bag 3005 Sydney Markets NSW 2129.