Queensland Government

Metro North Hospital and Health Service

Transition Care Program

CLIENT CO-PAYMENT REQUEST OUTCOME

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Transition Care Program has a co-payment of 17.5% of the aged care pension for Community TCP or 85% for Residential TCP.

Your request for a reduced fee because of financial hardship has been reviewed.

☐ Based on the information provided a fee reduction **has been approved**

☐ Based on the information provided a fee reduction **has not been approved**

The fee payable for the Transition Care Program is $ ..... per week.

I acknowledge that I have read and understood the information above.

Client signature: ..... Date: ..../..../....

Witnessed by: ..... Date: ..../..../....

Clinician name: ..... Designation: .....

Department: ..... Contact no: .....

Please email completed form to Central_Referral_Unit@health.qld.gov.au

Office use only

Finance application processed date: ..../..../....

Business Manager – Community & Oral Health Signature: .....

CLIENT CO-PAYMENT REQUEST OUTCOME

DO NOT WRITE IN THIS BINDING MARGIN

MR ADM 13020
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