



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

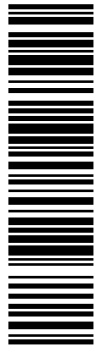
Do not reproduce by photocopying

All clinical form creation and amendments must be conducted through Health Information Services

MR ADM 13020

V2.00 - 11/2019

Locally Printed



00615:13020