Queensland Government

Metro North Hospital and Health Service

Transition Care Program

REQUEST FOR REDUCTION OF CLIENT CO-PAYMENT

(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.

☐ I wish to request a reduction in my co-payment due to financial hardship whilst I am on the program.

☐ Community ☐ Residential

If you are requesting a fee reduction it will be necessary to provide separate details as to why you should be given extra consideration.

Your case manager will assist you with completing this form and will submit your application to the Executive Director who will assess your application for approval

If you pay a reduced fee because of financial hardship you will still be provided with all services of the Transition Care Program.

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

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

Referrer name:.. Designation:....................

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

Email:..

Please email completed form along with Financial Situation Review Template to:
Central_Referral_Unit@health.qld.gov.au

Notification of the outcome of the reduced co-payment request will be emailed back to the referrer.

Office use only

☐ Endorsed / ☐ Not endorsed:.................................... Date: ...../...../.....

☐ Approved / ☐ Not approved:.................................... Date: ...../...../.....

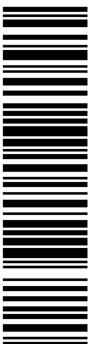
Business Manager name:.................................... Signature:....................

REQUEST FOR REDUCTION OF CLIENT CO-PAYMENT

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 13018
V2.00 - 11/2019
Locally Printed



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