

## Redcliffe Hospital Concession Parking Application Form

Completed form to be submitted to the Social Work Assistant, Admissions Counter, Redcliffe Hospital

### Part A – Applicant to Complete

Name of Applicant	Patient Name
Are you: the patient <input type="checkbox"/> the primary carer <input type="checkbox"/>	Type of concession: extended stay <input type="checkbox"/> frequent attendee <input type="checkbox"/> financial hardship <input type="checkbox"/> special consideration <input type="checkbox"/>

### Acknowledgement

By signing this application form, you acknowledge and agree:

- You are the person responsible for payment of the car parking fees at the hospital outlined above;
- You understand only one person may apply for car parking concession in connection with the Patient named above (either as patient or primary carer) and you are not aware of any other application that has been made in connection with this patient;
- You have provided all information which may be relevant in assessing your eligibility under this policy including any documentation that has been requested by the hospital to support your application and;
- All information you have provided is true and correct to the best of your knowledge.

Signature of Applicant	Date:
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### Part B – Clinical Staff to Complete

Office Use Only

Name of treating team / clinician	Date
Confirmation of treatment plan: Yes <input type="checkbox"/> No <input type="checkbox"/>	Patient UR

Frequent attendee	<i>Please note the patient is eligible after two weeks of two or more appointments per week.</i>	
	More than twice per week:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Duration of attendance From: ____/____/____      To: ____/____/____	

CNC / NUM Approval	Signature:	Date: ____/____/____
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Extended stay	<i>Please note the patient is eligible if their stay is for fourteen (14) consecutive days or longer.</i>	
	Please provide detail:	
	Duration of attendance From: ____/____/____      To: ____/____/____	

CNC / NUM Approval	Signature:	Date: ____/____/____
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Social Work Authorisation	Name	Signature
	Position title	

Concessional rate expiry	Date: ____/____/____	Official stamp
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**Part C – Social Work to Complete****Office Use Only**

Financial hardship	<b>Please provide detail:</b>	
	Duration of attendance From: ____/____/____ To: ____/____/____	
Special consideration	<b>Please provide detail:</b>	
	Duration of attendance From: ____/____/____ To: ____/____/____	
Social Work Authorisation	Name	Signature
	Position title	
Concessional rate expiry date	Date: ____/____/____	Official stamp

**Photo ID**

Photo ID verified by Social Work	Name	Signature
	Position title	
	Date: ____/____/____	