Redcliffe Hospital

Concession Parking Application Form

Submit completed form to the Admissions Counter, Redcliffe Hospital

ADMISSIONS STAFF TO COMPLETE

REFERENCE NO:

CONCESSION RATE: %

PATIENT UR:

Part A – Applicant Details	
Name of Applicant:	Patient Name:
Are you: the Patient ☐ the Primary Carer ☐	Type of concession: Extended Stay ☐ Frequent Attendee ☐ Financial Hardship ☐ Special Consideration ☐

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;
- 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:

Part B – Approving Staff to Complete (applicable section only)		**Office Use Only**
Name of Treating Team/Clinician:	Ward/Clinic:	
Frequent attendee	*Please note: the patient is eligible after two weeks of two or more appointments per week.*	
	Duration of attendance From: _____/_____/_____ To: _____/_____/_____	
CNC Approval	Signature:	Date: _____/_____/_____
Extended stay	*Please note: the patient is eligible if their stay is for fourteen (14) consecutive days or longer.*	
	Duration of attendance From: _____/_____/_____ To: _____/_____/_____ Eligibility for concession met at another MNH Facility *(circle)*: Yes / No	
NUM Approval	Signature:	Date: _____/_____/_____
Financial hardship	*Please note: Social Work Services or Facility Services Director to assess eligibility.*	
	Duration of attendance/treatment From: _____/_____/_____ To: _____/_____/_____	
SW or FSD Approval	Name:	Date: _____/_____/_____
Special consideration	*Please note: Admissions Staff will seek approval from Facility Services Director*	
	Duration of attendance From: _____/_____/_____ To: _____/_____/_____	
Email Approval By	Name:	Date: _____/_____/_____

Part C – Admissions Staff to Complete		**Office Use Only**
Admissions Staff Authorisation	Name:	Official Stamp
	Signature:	
Concessional Rate Expiry Date	Date: _____/_____/_____	

Part D – Photo ID Admissions Staff to Complete		**Office Use Only**
Photo ID verified by Admissions Staff	Name	Signature
	Date: _____/_____/_____	