Ontario

Ministry of Health and Long-Term Care

Northern Health Travel Grant Application

Print clearly in block letters. Ensure BOTH sides of this application are completed.

Pages 3 and 4 must both be submitted together.

For Ministry Use Only – Do not write here

Section 1 Patient Information (Refer to instruction sheet for more information)

Last Name	First Name	Health Number

Date of Birth (yyyy/mm/dd)	Home Telephone Number	Work Telephone Number	**Fee Code K036**

Home Address (Street Number and Street Name) Lot/Conc/Twp.

City/Town	Province	Postal Code

Mailing Address (if different from above, Box Number, RR Number, site)

City/Town	Province	Postal Code	Response Preferred in ☐ English ☐ French

Type of Transportation

Automobile (Receipts not required)	☐ One Way	☐ Round Trip						
Commercial Carrier **(Original tickets/stubs required)**	☐ Air	☐ Rail	☐ Bus					
Ambulance	☐ One Way	☐ Round Trip						
Number of lodging nights necessary for the patient to access medical care:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8+ nights

Are this patient's **travel costs** eligible for reimbursement from another program/organization?

☐ No ☐ Yes, WSIB ☐ Yes, Private Insurance (e.g. third party liability) ☐ Yes, NIHB- Non-insured Health Benefit Program for eligible First Nations and Inuit people

By completing and signing this application, I consent to the MOHLTC's collection, use and disclosure of the personal health information I have provided on this form for the purpose of processing my application under the NHTG Program including determining my eligibility, auditing compliance and payments made under the program and monitoring, preventing and recovering any unauthorized receipt of any grant paid under the program. I understand that the MOHLTC may use and disclose this information in accordance with the *Personal Health Information Protection Act, 2004.*

I hereby certify that I am the: ☐ Patient ☐ Parent of a patient who is under 16 years of age ☐ SDM of the patient (see instructions)

Signature

Section 2 Northern Referring Provider Information

Referring Provider's Last Name	Initials	Provider Number	Specialty

Specialist/Facility Referred to	Referring Provider's Telephone Number

Municipality Referred to	Did you see the patient in Northern Ontario? ☐ Yes ☐ No	Referring Provider's Fax Number

Is this referral to the specialist or facility nearest to the patient's area of residence that is capable of providing the required service? ☐ Yes ☐ No Please explain

I certify that based on my professional judgement, the patient is **unable to travel without a companion.** **Referring Provider's Signature**

I certify that the information provided in this section is correct. **Referring Provider's Signature**

Section 3 Specialist / Health Care Facility Service Provider Information

Last Name of Specialist/Service Provider	Initials	Professional Designation (if applicable)	Provider Number	Specialty

Name of Hospital/Facility where Service Provided (if applicable)	City/Town Service Provided in

Is this service for a ☐ Consultation ☐ Procedure ☐ Surgery ☐ Follow Up Visit ☐ Other — **Date of Service** (yyyy/mm/dd)

Is this medical service for an OHIP insured service?	☐ No	☐ Yes	
Is this service WSIB related?	☐ No	☐ Yes	
Is this medical service for an ADP approved device?	☐ No	☐ Yes (provide ADP Vendor Number)	
Is this medical service part of the Cleft Lip and Palate Program?	☐ No	☐ Yes (provide Program Number)	

Number of lodging nights necessary for the patient to access medical care: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ nights

I certify that the information provided in this section is correct.

Specialist / Health Care Facility Service Provider's Signature	**Telephone Number**	**Fax Number**

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Patient Information (Required on both sides of the form)

Last Name	First Name	Health Number

Section 4 Advance Funding by Third Party Agency/Society (if applicable)

Name of Society or Agency	Code Number

Mailing Address

Municipality	Province	Postal Code	Telephone Number ext.

I hereby direct the ministry's NHTG Program to pay my travel grant pertaining to this Northern Health Travel application to the society or agency named above.

Signature of Patient / Parent / SDM of the patient (see Instructions)

Section 5 Companion Information (if applicable)

Last Name	First Name

☐ Same as Patient Address

Mailing Address

City/Town	Province	Postal Code

Type of Transportation

Automobile (Receipts not required)	☐ One Way	☐ Round Trip	
Commercial Carrier **(Original tickets / stubs required)**	☐ Air	☐ Rail	☐ Bus
Ambulance	☐ One Way	☐ Round Trip	

I hereby certify that I am 16 years of age or older and I accompanied the above-named patient.

The personal information you provide on this form is necessary for the proper administration of the ministry's NHTG Program. The MOHLTC collects and may use and disclose this information for the purposes described in Section 1 above. If you have any questions about this collection, please contact the Manager, NHTG Program at 199 Larch Street, Suite 801 Sudbury ON P3E 5R1 or by phone at 705-675-4010 or 1-800-461-4006.

Companion's Signature	**Telephone Number**

Print Form

Clear Form