MEDICAL TRANSPORTATION ASSISTANCE PROGRAM

IN PROVINCE FLIGHT VOUCHER APPLICATION

Section 1: Applicant Information – Provide the information of the applicant traveling for the medical appointment.

Last name:	First Name:	Phone Number:
MCP#	MCP Expiry Date:	Date of Birth:

Residential Address:	City/Town:	Province:	Postal Code:
Mailing Address (If different):	City/Town:	Province:	Postal Code:

Email: Preferred Contact Method: Email ☐ Phone ☐ Mail ☐

Do you have health insurance coverage either through work or privately purchased (i.e. Blue Cross, Canada Life, belairdirect etc.)?
Yes ☐ No ☐ If Yes, Name of Insurance Provider:

Are you a Subsidized Home Support recipient or in receipt of Income Support Benefits? Yes ☐ No ☐
If yes, please contact Income Support Medical Transportation at 1-833-729-6106 for more information about receiving medical travel assistance.

Section 2: Escort Information – If applicable, provide the information of the escort. An escort must be medically required and supported by medical documentation from a physician.

Last Name:	First Name:	Date of Birth:

Relation to Patient: Parent ☐ Spouse ☐ Other:

Section 3: Details of Medical Travel – Please complete applicable sections below and note the required supporting documentation.

Appointment Location:	Date of Appointment (YYYY/MM/DD):
Patient Airport Origin:	Patient Airport Destination:
Escort Airport Origin:	Escort Airport Destination:

Primary Diagnosis:	Insured Service Required:	Reason for Travel[1]:

[1] Reasons for Travel can include Specialist Appointments, Treatments (e.g. Cancer/Dialysis), and Specialized Testing.

Do you require a round trip ticket? Yes ☐ No ☐ Does your escort require a round trip ticket? Yes ☐ No ☐

Please confirm the following supporting documentation, if applicable, has been included with your claim

Document Type: Confirmation of Appointment ☐ Medical Support for Escort ☐

Section 4: Declaration of Eligibility for Medical Transportation Assistance – The below declaration must be signed before processing of the application can occur. Unsigned applications will be considered incomplete and will not begin the review process.

• I declare that the information provided on this application is true and correct to the best of my knowledge.

• I understand that this information is collected by the Department of Labrador Affairs pursuant to section 61(1)(c) of the *Access to Information and Protection of Privacy Act, 2015* as such information relates directly to and is necessary to, and will be used to determine eligibility for reimbursement of eligible expenses in accordance with the Medical Transportation Assistance Program criteria and conditions, which may include discussions with parties from the Department of Health and Community Services.

• I understand and agree that I have 12 months from the date of my eligible insured specialized medical service to submit a MTAP Claim for the medical travel assistance I received through the Out of Province Airfare Partial Pre-payment Program. I also understand and agree that my failure to submit a claim within this time period may result in the recovery of this medical travel assistance by the Department of Labrador Affairs.

• I understand and agree that the information I submit may be subject to verification by officials of the Department of Labrador Affairs and that medical travel assistance provided to me in error is subject to recovery by the Department of Labrador Affairs.

• I understand that if I have private health insurance benefits, medical travel expenses must be assessed by the private insurance provider prior to submitting a claim to the Department for assessment and that any monies paid by private insurance must be disclosed in the form of a copy of the private insurance assessment and attached to the application form.

• I authorize the Department of Labrador Affairs to contact and share information with any other parties identified in this application for the purpose of verifying medical services received.

• I declare that financial assistance for medical travel was not provided by the Department of Children, Seniors and Social Development, Department of Health and Community Services, Workplace NL, or any other Federal/Provincial Government Department, Agency, Board, Commission, or Regional Health Authority.

• I authorize the Department of Children, Seniors and Social Development and/or any other parties identified in this Declaration of Eligibility to release the requested program-related information to the Department of Labrador Affairs.

• I authorize the Department of Labrador Affairs to disclose my personal information to third parties for the purposes of such third parties verifying individual eligibility to book air travel at a lower cost under the Medical Transportation Assistance Program, including the applicant's name, escort(s) name(s) (if applicable), address, travel authorization number, trip type, travel destinations, issue and expiry date for travel authorization and MTAP subsidy information. I further acknowledge that such third parties will provide information to Department on flights booked by applicants/escorts and associated costs, as well as reports on purchased tickets that were cancelled, changed, transferred or resulted in no shows.

If you have any questions about how this information will be collected, used and disclosed, please contact the Department at 1-877-475-2412

I _____ hereby declare that I am the person named on this form and I am a resident of Newfoundland and Labrador. In lieu of a written signature my typed name on the form shall be considered my electronic Signature.

Applicant's Signature: _____ **Date:** _____
(Electronic or Written)

Completed application, along with the required supporting documentation can be emailed to: PALFlightVoucher@gov.nl.ca

Print **Reset**