MEDICAL TRANSPORTATION ASSISTANCE PROGRAM

IN PROVINCE FLIGHT PASS APPLICATION

You MUST submit an MTAP post-travel claim within six months after travel to be eligible for a future pass

Section 1: Claimant Information

Last Name:	First Name:	Phone Number:
Jeffrey	John	709-555-0101
MCP#	**MCP Expiry Date (YYYY/MM/DD):**	**Date of Birth (YYYY/MM/DD):**
123456789011	2027-12-01	1989-05-25

Residential Address:	City/Town:	Province:	Postal Code:
123 Duggan Ave.	Fallview	NL	Z9Z6U6
Mailing Address (If different):	**City/Town:**	**Province:**	**Postal Code:**

Email: DonnaStaple123jc@gmail.com

Does the patient have health insurance from their job or insurance bought themselves (i.e., Blue Cross, Canada Life, belairdirect, etc.)? Yes ☑ No ☐ **If Yes, Name of Insurance Provider:** Great West Life

Medical travel expenses MUST be reviewed by the private insurance provider, and the resulting assessment MUST be submitted with the post-travel claim.

Is the patient eligible to receive travel support for this trip from another department, organization (e.g. Hope Air), employer, or government, including the Non-Insured Health Benefits program (NIHB)? Yes ☐ No ☑

Is the patient receiving Income Support, Home Support, or Financial Benefits through the Community Support Program? Yes ☐ No ☑

If yes, please apply to the Medical Transportation Supports (MeTS) Program at 1-833-729-6106 for medical travel assistance.

Section 2: Escort Information – An escort must be medically required and supported by medical documentation from a physician or nurse practitioner.

Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
Staple	Donna	1989-01-17

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:	Primary Reason for Travel:
Health Science	Specialist Physician Consultation
Date of Appointment (YYYY/MM/DD):	**Condition, Illness, or Physician Specialty:**
2026-08-13	Cardiologist
Patient Is Departing From:	**Patient Is Arriving To:**
Happy Valley-Goose Bay	St. John's
Escort Is Departing From:	**Escort Is Arriving To:**
Happy Valley-Goose Bay	St. John's

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

• 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 a post-travel claim for assistance received through an in-province flight pass application must be submitted within six (6) months of the eligible insured specialized medical service; that flight passes are limited to three consecutive trips within a six (6) month period unless a related claim is submitted; that failure to submit a post-travel claim may restrict eligibility for future flight passes; and that failure to submit a post-travel claim within twelve (12) months may result in recovery of 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 before submitting my required post-travel 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 claim 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, and for auditing purposes.

• I declare that I am not eligible for or have not received financial assistance for medical travel from the Department of Social Supports and Well-Being, Department of Health and Community Services, Workplace NL, NL Health Services, or any other funding received from an Agency, Board, Commission, organization (e.g. Hope Air) or Provincial/Federal Government or program, including the Non-Insured Health Benefits Program.

• I authorize the Department of Social Supports and Well-Being 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 to verify eligibility for reduced-cost air travel under the Medical Transportation Assistance Program (MTAP), including my name, address, and date of birth; the name and date of birth of any approved escort (if applicable); travel authorization details (number, trip type, destinations, and issue/expiry dates) for myself and any escort; and MTAP subsidy information, and I acknowledge that such third parties may provide the Department with information on flights booked, associated costs, and tickets that are cancelled, changed, transferred, or unused.

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 John Jeffrey **hereby declare that I am the person named on this form and I am a resident of Newfoundland and Labrador. Instead of a written signature, my typed name on the form shall be considered my electronic Signature.**

Applicant's Signature: John Jeffrey **Date:** Jun 2, 2026

(Electronic or Written)

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

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