Ontario

Ministry of Health and Long-Term Care

Application for Northern Health Travel Grant

The Northern Health Travel Grant (NHTG) Program helps defray travel related expenses of eligible Northern Ontario residents seeking medical specialist services or procedures at a designated health facility (e.g. CAT scan). Ministry travel grants are based on the distance to the closest medical specialist or designated health care facility able to provide the required health care services without a delay that would compromise the patient's health.

Please consider Telemedicine instead of travel: Ontario Telemedicine Network (OTN) supports almost every clinical specialty and may be an alternative to having patients travel. The OTN referral form is available at www.otn.ca/refer

Please note:

- Patient must complete and submit a new, separate application for ***each*** round trip.
  Submit your application to: Ministry of Health and Long-Term Care
  199 Larch Street, Suite 801, Sudbury ON P3E 5R1
- Your NHTG application must be received by the Ministry of Health and Long-Term Care (MOHLTC) within twelve (12) months from the date of service.
- Requests for re-consideration/re-assessment of applications must be received within twelve (12) months from the date of payment, grant denial or date claim is returned to a client.
- Original tickets/stubs/receipts must be provided for travel by air, bus or rail for patient and/or companion; however, travel itineraries are acceptable if they show a fare was paid or accumulated airline travel credits were used. Do ***not*** submit receipts for gas or meals since these are not required and will not be returned.
- If several patients/their companions travel together in the same car, only one travel grant will be paid per round trip.
- 100 kms will be deducted from the total distance of the trip when calculating the amount of the travel grant.

Eligibility Criteria for a Patient Travel Grant – Patient ***must*** satisfy all of the following:

☐ 1. Must be a resident of Northern Ontario in the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury, Thunder Bay or Timiskaming ***and*** be an OHIP insured person on the date the service is provided.

☐ 2. Must be referred within Ontario or to Manitoba for specialist health care or designated health facility procedures that are insured services under the *Health Insurance Act*.

☐ 3. Must have travelled at least 100 kms (one way road distance) to obtain the required service from their area of residence to the location of the nearest medical specialist/designated health care facility referred to in Ontario or Manitoba.

☐ 4. Must be referred, before the travel takes place, by a northern physician, dentist, optometrist, chiropractor, midwife or nurse practitioner and ensure Section 2 of the application is completed.
Note: No additional referral is required within a 12 month period from initial referral/service date for travel to the same specialist/facility.

☐ 5. Must be referred to a ***medical specialist*** who is certified by The Royal College of Physicians and Surgeons of Canada (RCPSC), or a ***Winnipeg (Manitoba) physician*** enrolled on the ***Manitoba Health Specialist Register*** and permitted to bill as a specialist. **OR** must be referred to a physician who holds a specialist certificate of registration issued by the College of Physicians and Surgeons of Ontario (CPSO) in a recognized medical or surgical specialty other than family or general practice, or a health facility designated by the MOHLTC.
To verify a specialist's RCPSC certification using the internet, go to www.royalcollege.ca and follow these steps:

i. Specify language (English or French) below "Directory of Fellows". Click: "Confirm Status". Read and accept Disclaimer.
ii. Enter doctor's last name and city. Click: "Search" and check specialty/subspecialty.

Contact the NHTG Program to find out if a particular health care facility has been designated by the ministry.

☐ 6. Must confirm that travel costs are not covered by another program/organization such as WSIB, NIHB (Non-Insured Health Benefit Program for eligible First Nations and Inuit people) or private insurance (e.g. third party liability). Contact the NHTG Program for additional details.

For Assistive Devices Program (ADP) applications where patient is referred for fitting, adjustments or repairs for ADP approved orthotics and prosthetics, both the following criteria must be met:

1) vendor has an ADP authorizer registration number; ***AND*** 2) travel is for one of the following devices:

– breast prostheses	– orthotics	– prosthetics	– conventional orthoses
– maxillofacial introral prostheses		– ocular prostheses	– burnscar pressure devices

Third Party Advance Funding – If any travel costs, including travel grant and/or accommodation allowance, have been covered in advance by an approved Third Party Agency, payment for which a patient is eligible will be made to that Third Party Agency. Contact the NHTG Program for additional details.

Eligibility Criteria for a Companion Travel Grant – Companion grant ***may*** be paid when all of the following are met:

1. Patient meets above travel grant eligibility criteria.
2. Patient is under 16 years of age on date of service or in the referring provider's professional judgement, patient is unable to travel without a companion. The referring provider must indicate this in Section 2 ***prior to the patient's travelling.***
3. Companion must be 16 years of age or older.
4. Companion must travel with the patient and pay a fare if travel is by air, rail or bus.

Eligibility for Accommodation Allowance – A patient ***must meet all of the following criteria*** in order to be eligible for the $100/round trip accommodation allowance:

1. The patient meets the travel grant eligibility criteria set out above: #1, 2, 4, 5 and 6.
2. The patient has travelled at least 200 kms (one way road distance) to obtain the required OHIP insured service from their area of residence to the location of the nearest medical specialist/designated health care facility referred to in Ontario or Manitoba.
3. The patient has submitted original accommodation receipts for services rendered on or after December 1, 2012.

0327-88E (2015/08) 7530-4419

Clear Form

Avoid Delays – Incomplete applications will be returned.

To assist you in completing your application, please provide the required information for all applicable sections using the following checklist as a guide. Please type or print clearly on all sections of the application. Ensure your most current name and address information have been provided to the MOHLTC. If your address information provided on this application does not match your health number records, this form will be used to update your records. ***Correctly completed applications will avoid delays in the assessment of your application and in your grant payment.***

Section 1: **Patient** completes this section in full:

- ☐ Last Name, First Name and Health Number
- ☐ Date of Birth, Home Telephone Number, Work Telephone Number and Sex
- ☐ Home Address and Mailing Address (if different than Home Address)
- ☐ Confirm if all/part of travel cost is covered by another program/organization
- ☐ Type of Transportation
- ☐ Provide Original Receipts/Stubs for travel by commercial carrier
- ☐ Patient's Consent and Signature
- ☐ Effective December 1, 2012, if applying for the accommodation allowance, provide Original Accommodation Receipts for each treatment trip (e.g. official hotel/lodging receipts)

If the patient is a child under 16 years of age, the child's parent/guardian with custody may complete and sign the form on behalf of the child. If the patient is 16 or older but incapable of consenting on his/her own behalf, a Substitute Decision Maker (SDM) may complete and sign the form on the patient's behalf.

SDM's include patient's:

- Guardian who has authority to make a decision on behalf of patient;
- Attorney for Personal Care who has authority to make a decision on behalf of patient;
- Representative appointed by Consent and Capacity Board with authority to give consent;
- Spouse/Partner;
- Child/Parent or children's aid society or other person legally entitled to give/refuse consent;
- Parent with only right of access;
- Brother/sister;
- Other relative.

For more specific information on SDMs, please contact NHTG program directly (see General Contact Information below).

Section 2: **Northern Referring Provider** completes and certifies:

- ☐ Last Name and Initial(s)
- ☐ Provider Number and Billing Specialty
- ☐ Name of Specialist/Facility referred to and location
- ☐ An indication if referral was made/not made to the nearest specialist from the patient's area of residence
- ☐ Signature
- ☐ Signature for Companion Grant Request (*if applicable*)

Section 3: **Specialist/Health Facility Service Provider** completes and certifies:

- ☐ Last Name and Initial(s)
- ☐ Professional Designation (e.g. R.N., Technician)
- ☐ Provider Number and Billing Specialty (*if applicable*)
- ☐ Name of Hospital/Facility and City/Town the service was provided in
- ☐ Type of Service (*e.g. procedure, follow up visit, other reason*)
- ☐ Date of Service
- ☐ Signature

Section 4: If patient received advance funding, **Third Party Agency** (*e.g. Canadian Cancer Society, Kidney Foundation*) provides:

- ☐ Agency/Society's Full Name
- ☐ Patient's Signature
- ☐ Code Number
- ☐ Municipality Location of the Society or Agency

Section 5: If applying for a companion grant, **Companion** completes this section in full:

- ☐ Last Name and First Name
- ☐ Mailing Address
- ☐ Type of Transportation
- ☐ Signature (*verifies companion is 16 years old or older*)
- ☐ Receipts/ticket stubs for travel by commercial carrier

If travel is round trip by car, ***one half*** of the grant may be paid to the patient and the ***other half*** paid to the companion.

General Contact Information:

- Office hours are 8:30 a.m. to 5:00 p.m., Monday to Friday except holidays.
- For more information, call 705 675–4010 or 1 800 461–4006.
- Or go to www.health.gov.on.ca/en/public/publications/ohip/northern.aspx
- To obtain services in French, please call the toll free number 1 800 461–1149

For current processing times, *go to our website*: http://www.health.gov.on.ca/en/public/publications/ohip/northern.aspx

Notice

The ministry cannot process your application unless you (and your companion, if applicable) provide the personal information required in sections 1 and 5 of the application. The ministry needs this information for the proper administration of the NHTG Program and will use and may disclose it for the purpose of determining your eligibility and processing your application. If you (and your companion, if applicable) do not consent to the ministry's collection, use and/or disclosure of this information, the ministry cannot process your application. For further information please contact the Manager, NHTG Program (see address information on previous page) or call 705 675-4010 or 1 800 461-4006.

Ontario

Ministry of Health and Long-Term Care

Clear Form

Pages 3 and 4 must both be submitted together.

Northern Health Travel Grant Application

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

*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** | **Fee Code K036**

Date of Birth (year / month / day) | Home Telephone Number ( ) | Work Telephone Number ( ) | Sex ☐ M ☐ F

Home Address (Street n°. and name) lot/conc/twp.

City/Town | O N | Postal Code

Mailing Address (if different from above, Box n°., R.R. n°., site)

O N | 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

Response Preferred in: ☐ English ☐ French

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, as set out in the Ministry's Statement of Information Practices, which may be accessed at www.health.gov.on.ca

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

X

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** X

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

Section 3 – Specialist / Health Facility Service Provider Information

Last Name of Specialist / Service Provider: SLORACH | Initials: P | Professional Designation *(if applicable)*: OCULARIST | Provider Number | Specialty

Name of Hospital/Facility Service Provided in *(if applicable)*: WEBB OCULAR | City/Town Service Provided in: TORONTO

Is this service for a: ☐ Consultation ☑ Procedure ☐ Surgery ☐ Follow Up Visit ☐ Other

Date of Service (year / month / day): 2016 01 17

Is this medical service for an OHIP insured service? ☑ Yes ☐ No

Is this service WSIB related? ☐ Yes ☑ No

Is this medical service for an ADP approved device? ☐ No ☑ Yes *(provide ADP Vendor N°)* 6833

Is this medical service part of the Cleft Lip and Palate Program? ☑ No ☐ Yes *(provide Program N°)*

I certify that the information provided in this section is correct. **Specialist / Health Facility Service Provider's Signature** X

Telephone No. 416 921-4931

Fax No. 416 921-2972

Turn over to next page ▶

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and Long-Term Care

Northern Health Travel Grant Application

Pages 3 and 4 must both be submitted together.

Please print clearly in block letters.

*For Ministry Use Only – **Do not write here***

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	Postal Code	Telephone Number	Extension
O N		( )	

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)*

X

Section 5 – Companion Information *(if applicable)*

Last Name	First Name

☐ Same as patient address

Mailing Address

City / Town		Postal Code
	O N	

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 St., Sudbury ON P3E 5R1 or by phone at 705 675–4010 or 1 800 461–4006.

Companion's Signature	**Telephone No.**
X	

Print Form

This form is also available at www.ontario.ca

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