



A TRADITION OF EXCELLENCE

St George's Hospital Inc



# Treatment Support Grant Application

Name of patient:	
Permanent Residential Address:	
Date of birth:	Occupation:
Medical insurer:	ACC prior approval:

**Reason for Support**  
**Clinical** – Brief clinical reason, need / benefit of treatment. (Please attach CPAC where available)

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**Financial** – Please provide brief financial details to confirm that the financial support is appropriate and will give relief, given the treatment cost and patient's circumstances.

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Requesting Ophthalmologist, Optometrist or General Practitioner:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY:**  
**Recommended by St George's Eye Care**

Estimated cost of treatment:	Recommended grant amount	
First Specialist Assessment / Diagnostic tests	\$ _____	\$ _____
Surgery	\$ _____	\$ _____
	Clinical Director	CEO, St George's Hospital Inc
Name:	_____	_____
Signature:	_____	_____
Date:	_____	_____

	Director 1	Director 2
Directors Name:	_____	_____
Directors Signature:	_____	_____
Date:	_____	_____

## ***Patient Consent and Declaration***

I, \_\_\_\_\_ both consent to the following and declare:

- 1 An application is being made on my behalf to the Health Assistance Committee of St George's Hospital Inc for a Treatment Support Grant relating to my proposed treatment at St George's Eye Care. I acknowledge that the Health Assistance Committee's decision is final and that not all applications for assistance will be successful in whole or in part; and
- 2 For the purposes of the Privacy Act 2020 and the Health Information Code, the release of my personal, medical and other information to the Health Assistance Committee, it's Directors and associated persons, for the purpose of considering any Treatment Support Grant application.

Having received an explanation from my referring medical specialist or the St George's Eye Care team as to the nature of the Treatment Support Grant application, I confirm that I have disclosed all relevant information about my financial circumstances (and any funds available to me) which I believe may be relevant to the Health Assistance Committee for the purpose of considering my application.

I confirm that I do not have full medical insurance cover, or I have exhausted medical insurance funds available for the treatment.

I accept that failure to attend for appointments, properly attend to reasonable requests for information etc or late cancellation could result in any offer of treatment assistance being withdrawn or lapsing.

**Date of Patient Consent:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **Signature:** \_\_\_\_\_