IMPORTANT

Australian Government
Department of Veterans' Affairs

Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)

Travel and Accommodation Claim Form

Use this form ONLY for

Claims and Reimbursements for out-of-pocket expenses related to travel and/or accommodation for treatment provided for accepted medical conditions of a VVSDSP registered client living in a rural and remote location with restricted access to public transport. This form is not intended to cover travel within metropolitan areas.

Information

As a guide, a registered person who lives in a rural and remote location with restricted public transport availability and who is required to travel more than 25 km (one way) will be considered for assistance with travel and accommodation to seek appropriate medical treatment. You are advised to check the VVSDSP Information Booklet to ensure you are eligible before applying for out-of-pocket expenses as you may be liable for the expenses if you do not meet the eligibility criteria. Travel, accommodation and meal allowances are paid at the current Department of Veterans' Affairs (DVA) Repatriation Transport Scheme (RTS) rates.

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

Filling in your claim

This form can be completed by you, as the eligible VVSDSP registered client, or (if applicable) a parent (of a minor child), a guardian or a person with Power of Attorney. Please complete and sign all relevant questions in the **CLAIMANT** sections and attach receipts, tax invoices and private health fund statements. Your service provider must complete the **SERVICE PROVIDER** section.

Complete this form carefully as an incorrect and/or incomplete form may be returned to you for completion.

Contact details

For enquiries relating to this claim please call **1800 550 504**

Please send your completed form to:

The Program Manager
Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)
Department of Veterans' Affairs
GPO Box 9998
Brisbane, QLD, 4001

SECTION A Claimant's Details

1 **The registered VVSDSP clients surname**

2 **Given name(s)**

3 **ID card number** *(if known)*

4 **Home address**

POSTCODE

5 **Postal address** *(if different from home address)*

POSTCODE

6 **Contact phone number(s)** [ ] Mobile

7 **E-mail**

8 **Are you claiming as the:**

☐ Client ☐ Parent (of a minor child)
☐ Guardian ☐ Person with a Power of Attorney

9 **Please give details if you are the parent (of a minor child), guardian or a person with a Power of Attorney** *(if applicable)*.

Surname

Given name(s)

10 **If applying as the guardian or the person with a Power of Attorney, was a certified copy of the guardianship or Power of Attorney sent with either the original registration form or subsequently?** *(if applicable)*.

No ☐ ▶ Please attach a certified copy of the guardianship order or Power of Attorney with this claim form.
Yes ☐

11 **As the guardian or the person with a Power of Attorney, is your mailing address the same as the registered VVSDSP client?** *(if applicable)*.

No ☐ ▶ What is your address?
Yes ☐

POSTCODE

Phone number [ ] Mobile

SECTION B Claim Details

12 **Travel**

Date / / Time am/pm

13 **For the return trip - what are you claiming?**

☐ Your own private vehicle km
☐ Public transport $
☐ Taxi $
☐ Community transport $
☐ Air (prior approval required) $
☐ Parking fees $
☐ Road tolls $

14 Did you travel with an attendant?

No ☐

Yes ☐ ▶ Name of your attendant

If admitted to hospital, did your attendant return home?

No ☐ Yes ☐

Note: a contributing allowance for your attendant may be paid by VVSDSP.

Accommodation and meal allowance

Please attach accommodation receipts

15 Were you admitted to hospital?

No ☐

Yes ☐ ▶ Please provide date and time

	Admission	**Discharge**
	/ / am/pm	/ / am/pm

16 Did you or your attendant require accommodation?

No ☐

Yes ☐ ▶ Please provide details below

	Claimant No. of nights	Attach Receipts	**Attendant** No. of nights	Attach Receipts
Commercial				
Subsidised				
Private				

Please ensure ALL receipts are attached with this claim (original or certified copies only). Processing of claims without documentation will be delayed until the documentation is received.

SECTION C Declarations and Consent Authorisation

17 Statement
(please tick appropriate boxes)

I hereby claim payment for travelling expenses and I declare that the expenses relate solely to the treatment of (please tick appropriate box(es):

☐ acute myeloid leukaemia;

☐ adrenal gland cancer;

☐ spina bifida manifesta;

☐ cleft lip; and/or

☐ cleft palate.

I acknowledge that, under VVSDSP, I will be entitled to financial assistance for my registered medical condition only. I undertake not to make any claims under the program for any other medical condition.

I consent and authorise the Department of Veterans' Affairs to obtain medical, clinical or other information from service providers and other relevant persons or bodies and/or to clarify details of the details of the travelling expenses for payment purposes.

I declare that the details I have provided in this form are, to the best of my knowledge, correct. I understand that giving false or misleading information is a serious offence.

Signature of VVSDSP registered client or (if applicable) parent (of a minor child)*, guardian* or person with Power of Attorney*

Date / /

Printed name

** By signing as the parent (of a minor child), guardian or person with the Power of Attorney you are accepting, on behalf of the applicant, that the information provided on this form is, to the best of your knowledge, correct.*

Payment will be sent by cheque or Electronic Funds Transfer (EFT). Details of EFT are only required if it is your first claim or the details have changed since your last claim.

SECTION D Funds Transfer (EFT) details

18 Give details of the account you want your payment made to.

Payments must be made to a bank, building society or credit union account held in your name. A joint account is acceptable.

Name of bank, building society or credit union

Type of account (e.g. savings, cheque)

Branch where your account is held

Branch number (BSB)

Account number (this is not always the number printed on your card)

Account held in the name(s) of

SECTION E Service Provider details

19 Provider type

20 Name

21 Treatment location address

POSTCODE

22 Telephone number [ ]

23 Provider number

24 Provider stamp

25 Was the treatment directly related to the client's VVSDSP registered medical condition?

No ☐ ▶ Please give reason

Yes ☐

26 To the best of your knowledge, are you the closest practical provider able to administer the required treatment?

No ☐

Yes ☐ ▶ Date(s) of treatment

/ / / / / /

I certify that I have provided treatment on the date(s) shown and the details are to the best of my knowledge correct.

Service provider signature

Date / /

If you are signing on behalf of the provider, provide your full name.

SECTION F Claimant - completed form

Please send your completed form together with accommodation receipts to:

The Program Manager
Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)
Department of Veterans' Affairs
GPO Box 9998
Brisbane, QLD, 4001

VVSDSP OFFICE USE ONLY

Date form received	/ /
Payment to supplier	$
Payment to claimant	$
Authorisation date	/ /
Authorised by (PRINT name)	
Signature	

Save Print Clear