Emergency Accommodation Service Grant
Form Preview

Referral from:

* indicates a required field

Useful information to help you complete this form:

- Family requiring accommodation assistance must reside a min of 30kms from GCUH.
- The patient receiving care must be an emergency admission or transfer. Assistance requests for Follow up elective surgery or treatment will not be considered unless the patient is re admitted into a critical care unit.
- Case for support notes must be complete to assess the referral
- Accommodation assistance is not covered once the patient moves to the ward
- Requests for extensions must be made weekly via email to the Foundation
- Decisions to supply accommodation is subject to availability and at the sole discretion of the Gold Coast Hospital Foundation
- Standard accommodation provided is a single room with 1 Double bed - multiple room accommodation requests will require a higher family contribution (negotiable with GCHF)
- Accommodation is provided and reviewed on a week by week basis with a maximum of 4 weeks accommodation provided.
- All incidentals booked to the Accommodation are the responsibility of the person/s staying in the room

To be completed by an authorised Nurse, Doctor or Social Worker .

Referring Social Worker *
First Name | Last Name

Referring Medical Specialist *
First Name | Last Name

Position *

Position *

Best Contact Number *

Must be an Australian phone number.

Best Contact Number *

Must be an Australian phone number.

Mobile Number

Must be an Australian phone number.

Email *

Must be an email address.

Email *

Must be an email address.

Referring Unit

Patient/Family Details

* indicates a required field

Patient Details

Referral has been discussed and consent has been give to pass on the following details: (referral cannot be made without consent) *

- ○ Yes
- ○ No

Patient Name *

Patient Age *

Type of injury/illness. Please provide a brief clinical description *

Hospital Admission date *

Must be a date.

Estimated length of hospital stay *

Please note that the GCH Foundation will review the Accommodation Assistance needs weekly.

Family details

Family member requesting assistance *

First Name Last Name

Mobile phone *

Must be an Australian phone number.

Email Address: *

Email address of family member

Address *
Address

Suburb State Postcode

Must be an Australian postcode.

Number of family members requiring accommodation: *

Must be a number.

Required date for check in *

Must be a date.

Estimated number of nights required *

Must be a number.

Details of Family to be accommodated. Ie: Brother / Parents and ages of all (for purpose of suitable accommodation): *

Provide a short description (100 words recommended) of your project - what are you out to do? Include whether they have their own transport or will be relying on Public transport

Social Status

* indicates a required field

Social status

Current Financial Situation *

Word count:
Must be no more than 150 words.

Eligible for: *
- ○ PTTS
- ○ IPTAAS
- ○ Not Eligible

Provide copies of IPTAAS forms:

Attach a file:

Is the family willing to make a Family contribution? *
- ○ $25 per night
- ○ No

If answered No, please state the reason *

Is the family willing to make a minimum Family contribution? *
- ○ $50 per night
- ○ No

Does the patient hold a pension / concession card *
- ○ Yes
- ○ No

If answered No, please state the reason *

New Question

Must be a date.

New Section

Assistance Requested

* indicates a required field

Case for Support Notes: (Provide additional information to support this application)

Case for Support Notes: (Provide additional information to support this application) *

Word count: