Ontario Ministry of Health

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 ministry funded health care facility (e.g. CAT scan). Ministry travel grants are based on the distance to the nearest medical specialist or ministry funded health care facility able to provide the required health care services without a delay that would compromise the patient's health.

Please note:

- 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
- Ensure your most current name and address information have been provided to the Ministry of Health (MOH). Your name and address information, as registered with the MOH will be used for identity assurance purposes. If your address information provided on this application does not match your health number records, this application will be used to update your records.
- Patient must complete and submit a new, separate application for **each** round trip.
- Your NHTG application must be received by the MOH 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, the date of grant denial or the date the claim is returned to a client.
- Tickets and/or itineraries for travel, showing who travelled, dates of travel, destination round trip and fare amount paid, must be provided for travel by air, bus or rail for patient and/or companion. Travel itineraries are acceptable if accumulated airline travel credits were used.

NOTE: The Northern Health Travel Grant (NHTG) program does not cover expenses for meals or taxi services. Do not submit these receipts as part of your application. Gas receipts should be kept for 12 months if we require proof of travel for audit purposes.

- If several patients / their companions travel together in the same car, only one travel grant will be paid per round trip.

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 health care facility-based procedures that are insured services under the *Health Insurance Act.*
3. Must have travelled at least 100 km (one way road distance) to obtain the required service from their area of residence to the location of the nearest medical specialist / health care facility referred to in Ontario or Manitoba.
4. Must be referred for specialty medical services. "Specialty medical services" means medical services rendered by the following:
   - **a medical specialist** who is certified by The Royal College of Physicians and Surgeons of Canada (RCPSC),
   - a **Winnipeg (Manitoba) physician** enrolled on the **Manitoba Health Specialist Register** and permitted to bill as a specialist,
   - **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,
   - **a general practitioner with a GP Focused Practice designation with the CPSO,**
   - **a non-specialist Dentist participating in the Cleft Lip/Palate Program or the Ontario Seniors Dental Care Program,**
   - **a ministry-funded health care facility.**

   To verify a specialist's certification online, go to CPSO website (https://www.cpso.on.ca) and follow the instructions. Contact the NHTG Program to find out if a particular healthcare facility is considered a ministry-funded healthcare facility.

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

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Eligibility for Accommodation Allowance – A patient must meet all of the following criteria in order to be eligible for the accommodation allowance:

1. The patient meets the travel grant eligibility criteria set out above: number 1, 2, 3, 4, and 5.
2. The patient has submitted original accommodation receipts (e.g., official hotel/lodging receipts) to prove a lodging expense was incurred. For patients under 18 years of age, an accommodation/lodging receipt may be in the name of the parent/guardian.

For all NHTG applications with a Service Date of December 1, 2024 or later, Accommodation Allowance of $175-$1,150 is paid, based on the number of medically-necessary lodging nights declared by the provider in Section 6. For all applications with a Service Date prior to December 1, 2024, the Accommodation Allowance range is $100 to $550.

Number of Nights	Service Dates before Dec. 1, 2024	Service Dates on or after Dec. 1, 2024
1	$100	$175
2	$200	$350
3	$250	$475
4 - 7	$500	$1,025
8+	$550	$1,150

Note: Ministry-funded healthcare facilities include those providing services the MOH directly and indirectly funds.

Information About Guardians and Substitute Decision Makers (SDM)

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 the NHTG Program directly (see **Contact Information – NHTG Program** at the bottom of the Instructions Section).

Assistive Devices Program (ADP) (For Providers)

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 an approved ADP device.

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

NHTG Internal Review Committee

NOTE: If you have additional information to support reconsideration of your application by the NHTG Internal Review Committee, please forward the information to the NHTG office at:

Northern Health Travel Grant
Internal Review Committee
Claims Service Branch
159 Cedar Street, 7th Floor
Sudbury, ON P3E 6A5

If there are exceptional medical circumstances surrounding your treatment trip, please provide a letter of support from your northern referring provider explaining those medical circumstances.

Submit your application to:	**Contact Information – NHTG Program**:
MOH – NHTG Program 159 Cedar St, 7th Flr Sudbury, ON P3E 6A5	Office hours are 8:30 a.m. to 5:00 p.m., Monday to Friday. Closed holidays. For more information, call 1-800-262-6524. Or go to https://www.ontario.ca/page/northern-health-travel-grant-program

Ontario **Ministry of Health**

Northern Health Travel Grant Application

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

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

Fields marked with an asterisk (*) are mandatory.

Section 1: Patient Information (Mandatory Section)

The Patient / Guardian / Substitute Decision Maker or Third-Party Agency must **complete sections 1, 2 (if necessary), 3 (if necessary), 4, and 5 in full**.

10-Digit Ontario Health Card Number *	2-Letter Version Code *	Note: If Last Name entered here, First Name is mandatory. * Last Name * Single Name * **or**

Middle Name	First Name * (not applicable if Single Name entered)	Date of Birth (yyyy/mm/dd) *	Response Preference * ☐ English ☐ French

Address Associated with Ontario Health Card Number *

Unit Number	Street Number *	Street Name *	PO Box	Postal Code *

City/Town *	Province *	Telephone Number *	Email Address

Alternate Mailing Address (if Necessary) *

If you wish to have correspondence related to this application sent to an alternate address than what is provided above, please enter this information below

Unit Number	Street Number *	Street Name *	PO Box	Postal Code *

City/Town *	Province *	Telephone Number *	Email Address

Type of Transportation *

Automobile (Receipts not required) ☐ One-Way ☐ Round-Trip

Commercial Carrier **(Require ticket/itinerary showing fare paid)** ☐ Air ☐ Rail ☐ Bus
- Was the Travel by Commercial Carrier one-way or round-trip? ☐ One-Way ☐ Round-Trip

Ambulance / Air Ambulance ☐ One-Way ☐ Round-Trip

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 Benefits Program for eligible First Nations and Inuit people

Did you travel with a companion? *

☐ Yes ☐ No

☐ I certify that I was not able to travel without a companion for this treatment trip. **(Only required if you answered "Yes" to the questions above)**

Important: Please submit accommodation receipts with this application.

Section 2: Companion Information (if applicable)

If applying for a companion grant, please complete this section in full.

Note: If Last Name entered here, First Name is mandatory. * Last Name * Single Name * **or**	First Name * (not applicable if Single Name entered)	Middle Name

Companion Mailing Address

Please enter the address you would like all correspondence sent to in regards to this application.

☐ Same as Patient Address	Unit Number	Street Number *	Street Name *	PO Box

Postal Code *	City/Town *	Province *	Telephone Number *	Email Address

Type of Transportation *

Automobile (Receipts not required) ☐ One Way ☐ Round Trip

Commercial Carrier (Require ticket/itinerary showing fare paid) ☐ Air ☐ Rail ☐ Bus
- Was the Travel by Commercial Carrier one-way or round-trip? ☐ One-Way ☐ Round-Trip

Ambulance / Air Ambulance ☐ One-Way ☐ Round-Trip

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Northern Health Travel Grant Application

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Section 3: Advance Funding by Third Party Agency/Society (if applicable)

If any travel costs, including travel grant and/or accommodation allowance, have been covered in advance by an approved Third Party Agency, please complete this section. Payment for which a patient is eligible will be made to that Third Party Agency.

Name of Society or Agency *			Code Number	
Unit Number	Street Number *	Street Name *	PO Box	Postal Code *
City/Town *	Province *	Municipality *	Telephone Number *	

☐ **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. ***

Section 4: Payment Preference (Mandatory Section)

NOTE: **Your bank statement will show a payment from "NOTS"**.
If **you chose not to complete this section, or select "No" below, the payment will be defaulted to a cheque payment via regular mail.**

Patient Enrolment for Direct Deposit

Do you wish to receive your grant via direct deposit to your bank account? ☐ Yes ☐ No

If you selected "Yes" to direct deposit, please include a **Payroll Direct Deposit Form or Void Cheque** with your grant application IF:

- This is the first time you have chosen to receive a grant payment via direct deposit

  or

- Your banking information you submitted previously has changed since you received your last grant via direct deposit

Travel Companion Enrolment for Direct Deposit *

Do you wish to receive your grant via direct deposit to your bank account? ☐ Yes ☐ No

If you selected "Yes" to direct deposit, please include a **Payroll Direct Deposit Form or Void Cheque** with your grant application.

COMPANIONS ONLY: Companions interested in receiving their payment via direct deposit MUST submit a NEW Payroll Direct Deposit Form or Void Cheque each time an application is submitted.

Section 5: Patient/Guardian/Substitute Decision Maker (SDM) Authorization (Mandatory Section)

Notice: The ministry cannot process your application unless you (and your companion, if applicable) provide the personal information required in sections 1 and 4 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 above address information) or by phone at 1-800-262-6524.

* **I hereby certify that I am the:**	* By completing this application, I _____ consent to MOH's (First Name_Last Name) collection, use and disclosure of the personal health information in accordance with the *Personal Health Information Protection Act, 2004*.
☐ Patient ☐ Parent / Guardian ☐ SDM of the patient (see instructions)	Patient / Guardian / SDM Signature *

Section 6: Speciality-Service Provider Information (Mandatory Section)

The Specialist-Service Provider must complete this section in full.

Date of Service (yyyy/mm/dd) *	Last Name of Specialist/Service Provider *	Initials *	Professional Designation	OHIP Billing Number

Specialty *	Name of Facility where Service Provided *	City/Town Service Provided In *	Telephone Number

Is this service for a	☐ Consultation	☐ Procedure ☐ Surgery ☐ Follow Up Visit ☐ Other	
Is this medical service for an OHIP insured Service?	☐ Yes	☐ No	
Is this service WSIB Related?	☐ Yes	☐ No	
Was the patient hospitalized during this treatment trip?	☐ Yes	☐ No	
Is this medical service for an ADP approved device?	☐ Yes	☐ No	If yes, provide ADP vendor number:
Is this medical service part of the Cleft Lip and Palate Program?	☐ Yes	☐ No	If yes, provide Program number:
Is this medical service part of Ontario Seniors Dental Care Program?	☐ Yes	☐ No	
Is this medical service part of Ontario Fertility Program (OFP)?	☐ Yes	☐ No	

Number of lodging nights necessary for the patient to access medical care: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ nights

Physician Fee Code: **K036**	I certify that the information provided is correct. Specialist Provider's Signature *