

Medical Travel Navigation Assistance Service Intake Form



Part 1: Patient Information

Full name			NCC membership #		
MCP			Birth date yyyy-mm-dd		
Address			Cell phone number or alternate number		
Community	Province	Postal Code	How would you prefer to be contacted? <input type="checkbox"/> Email <input type="checkbox"/> Phone call		
Email			Do you have a credit card or access to a credit card? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you covered for any of these expenses under any other health plan or program? Examples include Income Support, group insurance, employee benefit from Union (NAPE, CUPE, PSAC, USW, etc.). <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please attach a copy of a detailed statement or explanation of benefits from other plan/program.					

Part 2: Income Information

Would you like to apply for a meal top-up from NCC? Yes No

If so, and you are 64 years of age or younger, you must provide net income from line 23600 of the latest income tax return for you and your spouse/partner to see if you qualify. This can be obtained from your notice of assessment or from Canada Revenue Agency by calling 1-800-959-8281.

Applicant	Net income
Spouse/Partner	Net income

Part 3: Appointment Information

Please attach proof of appointment. If you have more than 1 appointment within 7 days, list all (print additional pages of this form if required)

Appointment date yyyy-mm-dd	Appointment time hh:mm
Reason for appointment / insured service required	
City	Province
Name of medical institution (e.g. Hospital name)	
Name of medical professional	Specialty of medical professional (e.g. Cardiologist)

Part 4: Travel details, if known

If there are multiple legs to your journey, please list all

Date / time of planned departure from community	Method(s) of travel
Date / time of planned return to community	Method(s) of travel

Part 5: Escort Requirements (for patients age 18+ and under 80)

Does patient require an escort? Yes No

If yes, please attach letter from physician outlining your requirement for an escort.

Part 6: Information Collection Statement

With the information we collect, we will only use this information to:

- Help arrange and coordinate medical travel.
- Support you in navigating appointments and related logistics.
- Help determine eligibility for travel or financial assistance programs.
- Communicate with you about your travel and support services.

We may share your information only when needed and only for the purposes above, with:

- Healthcare facilities or appointment offices.
- Travel providers (such as airlines or accommodations).
- Organizations that administer funding or support programs.
- Your union, or benefits provider, if this service is offered through them.

Your information is protected using reasonable safeguards and handled in accordance with privacy laws, including the *Personal Health Information Act* and other applicable legislation.

Part 7: Client Consent

I, _____, understand and have read the above information and consent to the collection and sharing of personal and medical information for the purpose of assisting with medical travel and related services.

Informed verbal consent obtained

Signature

Date

Office use only

Date received

Program client referred to

Intake completed by