

# APPLICATION FOR ADMISSION

Respite ☐ Residential Care ☐ Urgent ☐

APPLICANT DETAILS	
Title: Mr/Mrs/Miss/Ms/Dr/Other	Date of Birth:
Surname:	
Given Names:	Preferred Name:
Address:	Postcode:
Telephone: Mobile	Home:
PENSION	
Pension Status: Full <input type="checkbox"/> Part <input type="checkbox"/> or Self-Funded Retiree <input type="checkbox"/> Pension Type: Centrelink <input type="checkbox"/> DVA <input type="checkbox"/>	
Pension Number:	Expiry Date:
DVA Number:	DVA Card Colour: Expiry Date:
MEDICARE	
Name on Medicare Card:	Expiry Date:
Medicare Number:	Position on Card:
PRIVATE HEALTH INSURANCE	
Health Fund Name:	Membership Number:
CURRENT MEDICAL PRACTITIONER	
Name:	Telephone:
Address:	Postcode:
HOME CARE SERVICES	
Are you receiving any home care services: Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Provider:	
FUNERAL ARRANGEMENTS	
Funeral Home where plans have been arranged:	Burial <input type="checkbox"/> Cremation <input type="checkbox"/>
ADVANCED HEALTH DIRECTIVE:	
Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes, please provide a copy on admission)	

# APPLICATION FOR ADMISSION

<b>RELATIVE/REPRESENTATIVE OF APPLICANT – Refer to Consumer Consent Forms</b>		
<b>ENDURING POWER OF ATTORNEY</b>		
Yes <input type="checkbox"/> No <input type="checkbox"/> (if <b>yes</b> , please provide a certified copy on admission)		
Same as First Nominated contact on consent <input type="checkbox"/> Same as Second Nominated contact on consent <input type="checkbox"/> Both First & Second Nominated Contact on consent <input type="checkbox"/>		
Enduring Power of Attorney (EPOA) Contact details		
EPOA 1 - Name:		Relationship to Applicant:
Address:		Postcode:
Telephone: Mobile	Home:	Work:
Email:		
Guardian (if applicable):		
Administrator (if applicable):		
EPOA 2 - Name:		Relationship to Applicant:
Address:		Postcode:
Telephone: Mobile	Home:	Work:
Email:		
Guardian (if applicable):		
Administrator (if applicable):		
<b>PERMANENT RESIDENTIAL CARE (Assets and Income Assessment):</b>		
Have you submitted the following forms: <i>Residential Aged Care – Calculation of your cost of care (SA457)</i> or <i>Residential Aged Care – Property Details for Centrelink and DVA Customers (SA485)</i> ?      Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>If yes and you have received the assessment outcome from the department, please attach a copy of the letter</b>		
Signature of Applicant or Representative completing form: _____ Date: _____		
<b>OFFICE USE ONLY:</b>		
Pre-admission Date:	Date of Admission:	Room:
RAD or RAC:	DAP or DAC:	Interest Rate:
Daily Care Fee:	Direct Debit:	Wi-Fi:
Phone Rental:	Phone Number:	