

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"/>
RELATIVE/REPRESENTATIVE OF APPLICANT – First Contact		Contact for All Accounts <input type="checkbox"/>
Name:		Relationship to Applicant:
Address:		Postcode:
Telephone: Mobile		Home: Work:
Email:		

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RELATIVE/REPRESENTATIVE OF APPLICANT – Second Contact		Contact for All Accounts <input type="checkbox"/>
Name:		Relationship to Applicant:
Address:		Postcode:
Telephone: Mobile	Home:	Work:
Email:		
ENDURING POWER OF ATTORNEY		
Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes , please provide a certified copy on admission)		
Same as First Contact <input type="checkbox"/>	Same as Second Contact <input type="checkbox"/>	Both First & Second Contact <input type="checkbox"/> Other <input type="checkbox"/>
If other , please provide contact details below:		
Name:		Relationship to Applicant:
Address:		Postcode:
Telephone: Mobile	Home:	Work:
Email:		
Guardian (if applicable):		
Administrator (if applicable):		
ADVANCED HEALTH DIRECTIVE:		
Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes , please provide a copy on admission)		
PERMANENT RESIDENTIAL CARE (Assets and Income Assessment):		
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"/>		
If yes and you have received the assessment outcome from the department, please attach a copy of the letter		
Signature of Applicant or Representative completing form: _____ Date: _____		
OFFICE USE ONLY:		
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:	