

Date of Application: _____

Care Recipient's Details

Surname: _____ Given Names: _____

Preferred Name: _____ Date of Birth: _____

How do you like to be addressed?: _____

Address: _____ Postcode: _____

Email address: _____ Ph: _____ Mob: _____

Gender: Male Female Transgender Religion: _____

Marital Status: Married Single Widowed In a committed relationship

Nationality: _____ Country of Origin: _____

Cultural Background: _____ Preferred Language: _____

Has an application for approval for admission to Residential Care been made to A.C.A.T? Yes No

Admission Type: Permanent Respite

Referral code for residential approval: -

For Respite Accommodation Only

Admission Date: _____ Discharge Date: _____

Previous Respite: Yes No No. of days respite since July: _____

Pension Details

Australian Pension: Yes No

Type of Pension: Full Part

Aged DVA

Pension Card No.: - - - Expiry date: _____

If DVA Card – please list colour: _____

Overseas Pension: Yes No Type of pension: _____

Self-funded retiree: Yes No Type of income: _____

Medicare Details

Medicare Card No.: - -

Please write the number of Medicare card in front of your name:

Please write the 'valid to date' e.g. 09 – 2023: /

Private Health Cover Details

Private Health Cover: Yes No

If yes, Fund Name: _____ Membership No.: _____

Diabetic Association Membership No: _____

Hearing Aid Association Membership No.: _____

Current Pharmacy Details

Current Pharmacy Name: _____ Phone: _____

Address: _____

Current GP and Specialist Details

Current GP Name: _____ Address: _____

Phone No: _____ Fax No: _____

Will your GP continue to treat you once you are in Residential Care? Yes No

If No, would you like to select one of the GPs at the Village? Yes No

Name of GP selected: _____

Medical Specialist Details

Medical Specialist Name: _____ Address: _____

Phone No: _____ Fax No: _____

Contact Details

NOK Primary Contact <i>Relationship:</i> _____	Name:	
	Address:	Postcode:
	Phone:	Mobile:
	Email:	

Contact Details	
Secondary Contact <i>Relationship:</i> _____	Name:
	Address: Postcode:
	Phone: Mobile:
	Email:
Enduring Power of Attorney <i>(please provide copy)</i>	Name:
	Address: Postcode:
	Phone: Mobile:
	Email:
Enduring Power of Guardianship <i>(please provide copy)</i>	Name:
	Address: Postcode:
	Phone: Mobile:
	Email:
Person Responsible for payment of account	Name:
	Address: Postcode:
	Phone: Mobile:
	Email:
Funeral Director	Name:
	Address: Postcode:
	Phone: Mobile:
	Email:
Guarantor Details	Guarantor 1 Name:
	Address: Postcode:
	Driver's licence no:
	Guarantor 2 Name:
	Address: Postcode:
	Driver's licence no:

CONSENT

I, _____,

(Name of Consumer/Representative)

- am aware that there may be risks involved in some activities I choose to participate in. I understand that IVF will inform me of the risks factors and I need to acknowledge and understand the information about the potential and actual risks involved and make an informed decision.
- shall ensure that I do not bring into IVF any equipment, appliance, apparatus or machines that are electrically powered, other than by battery, unless each item has been tested and tagged as safe for use in the facility in accordance with the Electrical Appliance Safety Testing Standard AS/NZS 3760:2003 or its replacement equivalent standard. I understand that all initial testing and all annual re-testing is carried out in accordance with this standard and must be done at my own expense.
- understand that the Italian Village Fremantle's insurance does not cover Care Recipient's personal belongings or money and if I wish to have these valuables insured, I need to make my own arrangements. I also understand that all valuables I keep are at my own risk.
- understand that all clothes must be labelled including the one worn on the day of admission.
- understand that, if I require the use of some equipment (e.g. shower trolley or hoist), I consent to have these equipment safely stored in my room or ensuite.
- understand that I need to vacate the room within 2 days post discharge or otherwise daily charges will apply (basic daily rate).
- understand that following the vacating of the room, any equipment or belongings left in the room will be disposed of at my expenses.
- understand that if I bring to the Village any equipment or appliance, I undertake to maintain it at my own cost.
- if I cause any damages to wall or door surfaces (e.g. hanging pictures or wall mounting TV), I agree to pay the cost of repainting the room (\$250) following the vacating of the suite.

Signed: _____

Date: _____

Assets and Income Information

Principal home details

Do you own your home? Yes No

If you own your home, do you live alone or do any of the following people reside with you and will continue to reside in the principal home after you enter the nursing home?

- Live alone
- Live with wife/husband/partner
- Live with a carer for more than 2 years
- Live with a dependent child
- Live with immediate family for more than 5 years

Are any of the above people receiving pension or income support payment (does not include carer allowance) Yes No

If you live alone, please provide the following information.

Assessable Assets		Assessable Income	
Home Value	\$	Australian Pension	\$
Ret. Village Contribution	\$	Other Gov't Payments	\$
RAD/Bond	\$	Foreign Pension	\$
Shares	\$	Rental Income	\$
Superannuation (lump sum)	\$	Dividends	\$
Managed Investments	\$	Superannuation Income	\$
Foreign Assets	\$	Foreign Income	\$
Real Estate Business	\$	Other Income	\$
Mortgage	\$		
Other Assets	\$		
Total Assets	\$	Total Income	\$

Have you lodged an Income & Assets Assessment with Centrelink? Yes No Date lodged:

If "yes", please provide a copy of the Fees letter you have received.

If "no", do you intend to lodge an Income & Asset Assessment with Centrelink? Yes No

When do you plan to lodge? Date: _____

Your Current Location

Please select from the list:

- | | |
|---|-----------------|
| <input type="checkbox"/> Home | Address: |
| <input type="checkbox"/> Other residence (e.g. with family) | Address: |
| <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Other nursing home | |
| <input type="checkbox"/> Transitional care | Please specify: |

Document Checklist

Please bring the following completed documents to your Admission Appointment

- ACCR or Support Plan *(if not previously provided)*
- Income and Asset Determination Letter or copy of Combined Asset and Income Assessment
- Copy of Enduring Power of Attorney *(if applicable)*
- Copy of Enduring Power of Guardianship *(if applicable)*
- Copy of Advanced Care Plan *(if completed)*
- List of medications and medical history from own GP

Office Use Only

All documentation Received: Yes No

Comments:

Method of Payment: RAD DAP RAD/DAP RAC DAC RAC/DAC Supported