Autumn Aged Care
Excellence | Every Resident | Every Time

APPLICATION FOR RESPITE OR PERMANENT CARE

☐ BENTONS LODGE ☐ CLOVELLY COTTAGE ☐ HAMPTON LODGE ☐ SKYE LODGE

Name of Applicant:		Date:
Date of Birth:		Country of Birth:
Gender:	Marital Status:	Religion:
Current Address:		
Suburb:	Postcode:	Phone:
Is applicant in hospital? ☐ Yes ☐ No	If yes, name of hospital:	
Has the applicant lived in permanent residential care previously? ☐ Yes ☐ No		
If yes, name of aged care home:	Date of Admission:	
If in an aged care home, has an accommodation deposit been paid? ☐ Yes ☐ No		
Local GP:		Phone:
NSAF Comprehensive Assessment Referral Code (please provide)	Respite: Permanent:	
Do you have connections or a relationship with anyone at Autumn Aged Care? ☐ Yes ☐ No If yes is there anything you would like us to know:		

Have you completed the Income & Assets Assessment? ☐ Yes ☐ No

Pension/Concession Card Number: ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐		Expiry Date:
DVA Card Number: ☐☐☐☐☐☐☐☐	Card Colour: ☐ Gold ☐ Blue ☐ White	
Full Pensioner: ☐ Yes ☐ No	Part Pensioner: ☐ Yes ☐ No	Non-Pensioner: ☐ Yes ☐ No
Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Pos No: ☐		Expiry Date:
Health Fund:	Health Fund Member Number:	
Do you have Ambulance Cover? ☐ Yes ☐ No	If yes, name of Ambulance Cover Provider:	

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RESIDENT REPRESENTATIVE (PRIMARY)	RESIDENT REPRESENTATIVE (SECONDARY)
Legal/authorised representative ☐ Yes ☐ No Name:	**Legal/authorised representative** ☐ Yes ☐ No Name:
Relationship to Resident:	Relationship to Resident:
Mobile: Landline:	Mobile: Landline:
Email: *For administration communication/invoices/Brenna*	Email: *For administration communication/invoices/Brenna*
Address:	Address:
Tick all that apply: ☐ **VCAT Appointed** ☐ **Guardianship** ☐ **Financial Administrator** ☐ **Appointed Medical Treatment Decision Maker or Enduring Power of Attorney (Medical)** ☐ **Enduring Power of Attorney (Personal)** ☐ **Power of Attorney or Enduring Power of Attorney (Financial)** ☐ **Nominated or Appointed Restrictive Practice Decision Maker** ☐ **Supportive Attorney** ☐ **Guardian** ☐ **Limited Order** ☐ **myagedcare Registered Supporter** ☐ **Billing Contact** ***Copy of above documentation required prior OR on admission***	Tick all that apply: ☐ **VCAT Appointed** ☐ **Guardianship** ☐ **Financial Administrator** ☐ **Appointed Medical Treatment Decision Maker or Enduring Power of Attorney (Medical)** ☐ **Enduring Power of Attorney (Personal)** ☐ **Power of Attorney or Enduring Power of Attorney (Financial)** ☐ **Nominated or Appointed Restrictive Practice Decision Maker** ☐ **Supportive Attorney** ☐ **Guardian** ☐ **Limited Order** ☐ **myagedcare Registered Supporter** ☐ **Billing Contact** ***Copy of above documentation required prior OR on admission***

☐ Additional Resident Representative Form required

Is there an Advance Care Plan/Care Directive in place ☐ Yes ☐ No

If no, when was information provided and is there a reason they don't have or don't want an ACD:

_____

A copy given on admission? ☐ Yes ☐ No Who has a copy? _____

How Did You Hear About Us?

☐ Health Professional
☐ Word of mouth
☐ Newspaper
☐ Magazine
☐ Billboard
☐ Search Engine (e.g. Google)
☐ My Aged Care
☐ Other Aged Care Support Service
☐ Other (please specify): _____

SIGNATURE	DATE