

Application for Residential Aged Care

Date completed

Which **Ibis Care** Residence are you applying to? Bexley Blakehurst Kirrawee Miranda MortdaleLevel of priority? Urgent Semi-urgent

Application to include (please tick):

 Copy of ACAT/NSAF assessment Copy of Centrelink/DVA Assets & Income Letter (if applicable) Copy of Enduring Power of Attorney/s financial and medical (if applicable)

Prospective Client Information

Title (please tick)

Other title (please specify)

 Mr Mrs Miss Ms

First Name?

Middle Name?

Last Name?

Preferred name?

Address:

Suburb?

Postcode?

Email Address?

Telephone?

Mobile Number?

Date of Birth?

Referral Source?

Country of Birth?

Gender?

Nationality?

Primary language spoken?

Do you need an interpreter? (Yes or No)

Current location?

Are you: Aboriginal Torres Strait Islander Aboriginal and Torres Strait IslanderMarital Status? Single Married Widowed Divorced Separated

Support Needs

Are you applying for? Permanent Respite Dementia SpecificDo you have a current NSAF/ACAT completed? Yes No

Approval Date of NSAF/ACAT?

Permanent Referral Code?

Respite Referral Code?

Pension and Benefits

Medicare card number?

Name as it appears on card?

Number on card?

Expiry date?

Do you hold an Australian Pension Concession Card? Yes NoIf yes, what type of pension? Age Disability Widow DVA Blind Overseas Self-Funded

Other Pension (please specify)

Pension card number?

Expiry Date?

What type of Pension do you receive? Full Part Self-Funded

If you hold a DVA Card, what type is it? Gold White Orange

DVA card number?

Expiry Date?

If DVA, please select from the following? Veteran's Affairs Service Pension War Widow Pension

Veteran's Affairs Income Support Supplement Veteran's Affairs Disability Pension POW

Are you an Australian Ex-Prisoner of War?

Health and Ambulance

Do you have Private Health Insurance? (Yes or No)

If yes, what is the name of the fund:

Membership number?

Level/Cover?

Do you have ambulance cover? (Yes or No)

If yes, what is your Membership number?

If applicable, what is your PBS Safety Card number?

Do you have a National Diabetes Service Scheme Card?

If yes, what is the number of the card?

Electoral, Religious & Cultural Information

Are you on the Electoral Roll? Yes No Unknown

Do you intend to say on the Electoral Roll? Yes No Unknown

Religious or Spiritual needs?

Do you have any specific cultural requirements? If yes, please provide details below:

General Practitioner

Do you have a General Practitioner who has agreed to provide medical care for you at Ibis Care? Yes No

Please note, it is essential that your General Practitioner agrees to visit you at Ibis Care or provides a locum service outside of normal business hours in the event of illness or injury.

If not, there are General Practitioners who routinely visit Ibis Care residences who can be your nominated General Practitioner. We can provide you with information.

If yes, please provide your General Practitioner's details:

General Practitioner name?

Practice?

Address?

Suburb?

Postcode?

Telephone?

Fax?

After Hours Number?

Mobile?

Email Address?

Pharmacist

Pharmacist Name?

Address?

Suburb?

Postcode?

Telephone?

Fax?

After Hours Number?

Mobile?

Email Address?

(Our preference is that all medications post admission will be packaged by the Ibis Aged Care nominated Pharmacy. Should you wish to continue the relationship with your usual Pharmacy Provider please speak to our Clinical Manager)

Hospital

Name of nominated Hospital for possible admission?

Admission Height (cm)

Admission Weight (kg)

Funeral Director & Advance Care Planning

Have prior funeral arrangements been made? Yes No

If yes, please name the nominated Funeral Director

Please indicate your wishes? Cremation Burial

Address of Funeral Director?

Suburb?

Postcode?

Telephone?

Fax?

After Hours Number?

Mobile?

Email?

Are you a registered organ and/or tissue donor? Yes No

Do you have an Advanced Health Directive? (If yes, please provide a copy) Yes No

Is an Advanced Health Directive to be completed? Yes No

Legal & Financial Management

Has anyone been appointed on your behalf as an:

General Power of Attorney:

Financial Medical Joint Severally

Enduring Power of Attorney:

Financial Medical Joint Severally

Enduring Guardian:

Financial Medical Joint Severally

Other:

Appointed Administrator (State Trustee) Billing Contact Consumer Representative/Emergency Contact

Guarantor Primary Contact Registered Supporter Restrictive Practices Decision Maker

Please note: a copy of each document will be required prior to admission.

Who should we send your monthly statements to?

Client Representative First Second or Third contact

Other (please provide details on following page)

Legal & Financial Management

Name

Address

Telephone?

Mobile?

Email?

Client's Representative (legal names must be used)

First Contact

First Name

Surname?

Address?

Suburb?

Postcode?

Home Contact?

Mobile?

Work?

Email?

Relationship to Client?

Are you the next of kin? Yes No

Are you the Emergency Contact? Yes No

Do you hold any of the following? (If yes, please tick):

General Power of Attorney:

Financial Medical Joint Severally

Enduring Power of Attorney:

Financial Medical Joint Severally

Enduring Guardian:

Financial Medical Joint Severally

Other:

Appointed Administrator (State Trustee) Billing Contact Consumer Representative/Emergency Contact

Guarantor Primary Contact Registered Supporter Restrictive Practices Decision Maker

Client's Representative (legal names must be used)

Second Contact

First Name

Surname?

Address?

Suburb?

Postcode?

Home Contact?

Mobile?

Work?

Email?

Relationship to Client?

Are you the next of kin? Yes No

Are you the Emergency Contact? Yes No

Do you hold any of the following? (If yes, please tick):

General Power of Attorney:

Financial Medical Joint Severally

Enduring Power of Attorney:

Financial Medical Joint Severally

Enduring Guardian:

Financial Medical Joint Severally

Other:

Appointed Administrator (State Trustee) Billing Contact Consumer Representative/Emergency Contact

Guarantor Primary Contact Registered Supporter Restrictive Practices Decision Maker

Client's Representative (legal names must be used)

Third Contact

First Name

Surname?

Address?

Suburb?

Postcode?

Home Contact?

Mobile?

Work?

Email?

Relationship to Client?

Are you the next of kin? Yes No

Are you the Emergency Contact? Yes No

Do you hold any of the following? (If yes, please tick):

General Power of Attorney:

Financial Medical Joint Severally

Enduring Power of Attorney:

Financial Medical Joint Severally

Enduring Guardian:

Financial Medical Joint Severally

Other:

Appointed Administrator (State Trustee) Billing Contact Consumer Representative/Emergency Contact

Guarantor Primary Contact Registered Supporter Restrictive Practices Decision Maker

Legal & Financial Details

Does the Client have a partner? Yes No

Partner's name?

Partner's age?

Partner's date of birth?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Will the partner remain at home? Yes No

Is the partner in care? Yes No

If yes, what date did they enter care?

Are both entering care at the same time? Yes No

Have you submitted an Assets and Income Assessment? Yes No

Have you received the Assets and Income Assessment letter? Yes No

Do you OR your partner have any other forms of income? Yes No

If yes, please indicate the type of additional income:

Superannuation Pension

Gross income received?

Deductible amount per annum?

<input type="text"/>	<input type="text"/>
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Allocated Pension

Gross income received?

Deductible amount per annum?

Asset value?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Will the asset be: Kept Sold

Overseas Pension

Gross income per annum (before Tax)?

Employment Income

Gross income per annum (before Tax)?

<input type="text"/>	<input type="text"/>
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Annuity (non-complying)

Total income received?

Deductible amount per annum?

Asset Value?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Other Income

Amount per annum?

Source of this income?

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 Do you currently own your home? Yes No

 If yes, will anyone remain living in the family home? Yes No

If yes, what are the current living arrangements?

 Living with a partner of dependent child

 Living with a carer, eligible for income support payments who has resided for over 2 years

 Living with a close relative, eligible for income support payments who has resided for over 5 years

 None of the above

What is the net market value of the family home?

 Do you intend to keep the family home? Yes No

 If yes, do you intend to rent the family home? Yes No

If yes, what will be the gross rental income per annum?

If yes, what will be the net rental income per annum?

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 Do you have any other real estate property other than your family home? Yes No

If yes, please complete the following:

Market value?

Gross rental income per annum?

Net rental income per annum?

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 Will the asset be: Kept Sold

 Have you gifted any assets away in the last 5 years? Yes No

If yes, please provide details:

Month?

Year?

Amount?

Assets & Investments

Does the potential Resident OR partner own any of the following assets? Yes No

If yes, please indicate the type of assets:

Home Contents?

Motor Vehicles?

Boats, Caravans or Trailers?

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Special collections, such as stamps, artwork, or antiques?

Does the potential Resident OR partner own any of the following investments? Yes No

If yes, please indicate the type of investments:

Cash not kept in financial institutions? Yes No

If yes, please indicate the amount?

Bank Accounts, Building Societies, Credit Unions? (If yes please provide details) Yes No

Bank Name?

Amount?

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Bank Name?

Amount?

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Shares, options, rights, convertible notes - in listed or unlisted companies? Yes No

Name?

Amount?

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Name?

Amount?

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Managed Funds? Yes No

Name?

Amount?

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Name?

Amount?

Insurance or Government Bonds? Yes No

Name?

Amount?

Name?

Amount?

A Funeral Bond? Yes No *(Investment policy allocated to funeral expenses)*

Name?

Amount?

A Prepaid Funeral? Yes No *(Funeral prepaid at Funeral Home)*

Name?

Amount?

Life insurance that can be encashed? Yes No

Name?

Amount?

Do you or your Partner have any debt? Yes No

If yes, what is the amount?

Home Care/Residential Aged Care History

Are you currently receiving, or have you ever received a Home Care Package? Yes No

If yes, please complete the following details:

Name of provider?

Contact number?

Start date of Home Care?

End date of Home Care?

Did you pay any Income Tested Care Fees for Home Care? Yes No

If yes, how much?

Are you currently receiving, or have you ever received, Respite or Permanent Care in Residential Aged Care?

 Yes No

If yes, please complete the following details:

Permanent Care:

Name of Provider?

Contact number?

Admission Date?

Discharge Date?

Did you pay any Means Tested Care Fees to this Provider? Yes No

If yes, how much?

Residents Financial entry status: *(Pre 1st July 2014 - ONLY)* Fully Supported Assisted

Accommodation charge per day?

Bond method of payment? Lump Sum Periodic Combination

Bond amount at date of entry?

Interest Rate?

Monthly Retention amount?

Number of Retentions deducted?

Bond Rollover amount?

(Post 1st July 2014 - ONLY)

Fully Supported Daily Accommodation Contribution (DAC)

Daily Accommodation Contribution (DAC) charge per day?

Refundable Accommodation Contribution/ Daily Accommodation Contribution (RAC/DAC)

RAC Amount?

DAC Amount?

Refundable Accommodation Deposit?

Refundable Accommodation Deposit (RAD) method of payment? Lump Sum Periodic Combination

If Combination: Lump Sum Amount?

DAP Amount per day?

Daily Accommodation Payment?

Permanent Care

Name of Provider?

Contact Number?

Admission Date?

Discharge Date?

How many Respite Days have you used in this Financial Year?