ROSHANA CARE GROUP

Admission Application Information

Date of Application ____________________ Date of ACCR ________________________

Thank you for your interest in Roshana Care. Please complete all details in full and return.
PLEASE PRINT DETAILS

Facilities

WA ☐ Carmel ☐ Sunshine Park ☐ Gwen Hardie ☐ Annie Bryson
☐ Dryandra ☐ Grandton

NSW ☐ Lee ☐ Uralba ☐ Moyne ☐ Macleay

QLD ☐ Parklands ☐ Bellevue

VIC ☐ Macleod Graceland Manor

CONSUMER'S DETAILS

Title: Mr. / Mrs. / Miss. / Ms. / Other: ____________________ **First Name:** ______________________________

Middle Name: ____________________________________ **Last Name :** ____________________________

Preferred Name: _________________________ **Date of Birth** (dd / mm / yyyy): _____/______/_______

Gender: ☐ Male ☐ Female ☐ Intersex or indeterminate ☐ Not stated/ inadequately described

I Describe myself as: ☐ Male ☐ Female ☐ Lesbian ☐ Gay

☐ Bisexual ☐ Transgender ☐ Intersex ☐ Other

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

(This field is for historical reference only-Please use the field below to record Aboriginal or Torres Strait Islander status.)

Aboriginal or Torres Strait Islander (Please Select):

☐ Neither Aboriginal nor Torres Strait Islander origin ☐ Aboriginal but not nor Torres Strait Islander origin

☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin

☐ Not stated/ inadequately described

Country of Birth: __________________________ Marital Status: _____________________

Primary Language: ________________________ Secondary Language: __________________

Religion: _________________________________ Currently Practicing: ☐ Yes ☐ No

Partner's first name/ given name:____

Partner's last name/ family name:____

TYPE OF ACCOMMODATION REQUESTED

☐ Single ☐ Large Single ☐ Double ☐ Shared

☐ Single Ensuite ☐ Single Shared Bathroom

Please refer to individual sites for room option availability.

Medicare Number: ______________________ Card Member Number: ____ Expiry Date: ______________

Name as it appears on Medicare Card: ____

PENSION STATUS:

☐ Non-Pension

☐ Full Pension Pension Number: ___________________________ Card Expiry Date: _______________

☐ Part Pension Pension Number: ___________________________ Card Expiry Date: _______________

☐ DVA ☐ White ☐ Gold DVA Card Number: ______________ DVA Card Expiry Date: _______________

☐ Overseas: Country: _________ Pension Number____

Private Health Insurance Provider: _______________________ Membership Number: ____________________

Ambulance Membership Number: __________________ Diabetic Association Number: __________________

PRESENT ACCOMMODATION

Address:

Home: ☐ Yes ____

Retirement Unit: ☐ Yes ____

Hospital: ☐ Yes ____

Residential Care: ☐ Yes - If yes please complete below details:

Previous care (Admitted from) :____

Phone Number: ____________________________ Email Address: ___________________________________

Address:

Country: _________________________ Street: ____

Suburb/ Town:_____________________ State:__________ Postcode:______

Current ACAT Assessment attached: ☐ Yes ☐ No

Is the Consumer on the electoral role? ☐ Yes ☐ No

Does the Consumer wish to remain on the Electoral Roles- State/Federal/Local ☐ Yes ☐ No

PERSON RESPONSIBLE FOR FINANCIAL DECISIONS:

☐ Consumer ☐ Enduring Power of Attorney ☐ Guardian ☐ Next of Kin (NOK)

"Original Documents" for Enduring Power of Attorney, Guardian, NOK are required to be provided at the time of admission.

PRIMARY CONTACT:

Primary Contact Relationship: ____________________

First Name: ____________________ Last Name: ____________________

Address:

Street: ____________________

Suburb: ____________________ State: ____________________ Postcode: ____________________

Primary Contact Telephone Numbers – Work: ____________________ Home: ____________________

Mobile: ____________________ Primary Contact Email Address: ____________________

PERSON RESPONSIBLE FOR MEDICAL AND LIFESTYLE DECISIONS:

☐ Consumer ☐ Enduring Power of Guardian ☐ Guardian ☐ Next of Kin

"Original Documents" for Enduring Power of Guardian, Guardian, NOK are required to be provided at the time of admission.

Secondary Contact:

Secondary Contact Relationship: ____________________

First Name: ____________________ Last Name: ____________________

Address:

Street: ____________________

Suburb: ____________________ State: ____________________ Postcode: ____________________

Secondary Contact Telephone Numbers – Work: ____________________ Home: ____________________

Mobile: ____________________ Secondary Contact Email Address: ____________________

Suburb/ Town:____________________ State:____________________ Postcode:____________________

INCOME AND ASSETS

Have you completed the Services Australia Income and Assets Assessment Paperwork? ☐ Yes ☐ No

Failure to update your details with SA may result in maximum fee charges

FINANCIAL STATEMENT

☐ I understand that if I do not disclose my assets that I will be charged the maximum fees

☐ Please include all assets, debts and income owned by yourself and your partner

ASSETS approximate value ☐ individual: single or ☐ Couple: combined

Home (exc contents) $__________
Home contents $__________
Other Properties (inc land) $__________
Shares/managed funds $__________
Terms deposits/bonds/debentures etc $__________
Bank accounts/credit unions/building services $__________
Superannuation/allocated pension benefit $__________
Loans to other parties $__________
Antiques/works of Art $__________
Motor Vehicles/boat/caravan $__________
Other assets $__________
Funeral bonds $__________
TOTAL ASSETS $__________

DEBTS

Mortgage $__________
Other debts/commitments owed $__________
TOTAL DEBTS $__________

GIFTING

Have you gifted away any assets in the last 5 years $__________
TOTAL GIFTING $__________

INCOME **Per fortnight**

Australian Aged Pension FULL PART $__________
Veteran Affairs Pension $__________
Overseas pension $__________
Other pension $__________
Income support supplement $__________
Property income (net) $__________
TOTAL INCOME: $__________

Does the Consumer Smoke: ☐ Yes ☐ No

PASTORAL CARE NEEDS:

Nominated Funeral Director: ______________________________

Address: ______________________________

Contact Number: ____________________ Service type: ☐ Cremation ☐ Burial

NAME OF FAMILY DOCTOR:

Will your General Practitioner Visit the facility: ☐ Yes ☐ No

General Practitioner Name: Dr.______________________________

Telephone Number: ____________________ Fax Number____________________

Email Address: ______________________________

West Australian admissions only: Have you been an inpatient in a Health Care Facility (HFC) or resided in a Residential Care Facility **outside** of Western Australia in the past 12 months? ☐ Yes ☐ No ☐ N/A

If "Yes" All Consumers who have been an inpatient in a Health Care Facility (HFC) or resided in a Residential Care Facility outside of Western Australia in the past 12 months will be required to be screened prior to facility admission. Your screening results would need to be "negative" prior to admission to our Western Australian Sites only

The following one set of screening swabs are required:

- **Nostrils (single Swab moistened with sterile water);**
- **Any wounds, ulcers or skin lesions;**
- **A catheter urine specimen if an indwelling or suprapubic urinary catheter is insitu;**
- **In addition, it is recommended that a throat swab is collected if decolonisation is to be undertaken on the return of a positive result and/or to increase sampling yield**

Ref: Department of Health Government of Western Australia. (OD0478/13). Infection prevention and control of Methicillin-resistant Staphylococcus aureus (MRSA) in Western Australian healthcare facilities. Perth, Australia": Department of Health Government of Western Australia.

Referred By: ☐ Family ☐ Advocate ☐ G. P ☐ Self ☐ DPS Guide ☐ Aged Care Online

Hospital: ____________________ Social Worker: ____________________ Phone: ____________________

I, (the name of the person completing this form) ______________________________

Of (current address) Address: ______________________________

Suburb: ____________________ State: ____________________ Postcode: ____________________

Do solemnly and sincerely declare that the information contained in this document, and the information contained in any documents submitted as part of this application, is true and correct to the best of my knowledge and belief.

Signed: ____________________ Date____________________