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(This field is for historical reference only-Please use the field below to record Aboriginal or Torres Strait Islander status)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