

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	NSW	VIC	QLD	SA
Carmel	Lee	Macleod	Parklands	Lerwin
Sunshine Park	Uralba	Graceland Manor	Bellevue	
Gwen Hardie	Moynes	Noble Park		
Annie Bryson	Macleay			
Grandton	Brentwood			
Dryanda	Parkes			

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(This field is for historical reference only-Please use the field below to record Aboriginal or Torres Strait Islander status.)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

How did you hear about us?

- Friend or Family
- Hospitals / Care worker
- Newspaper
- Radio
- Television Ad
- Facebook
- Instagram
- Digital screening (IGA or Medical centres)
- LinkedIn
- YouTube
- Online search
- Website
- Handout
- Community Event
- Other (Please specify):
