

Date of Application _____

Date of ACCR _____

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

Facilities

- | WA | NSW | VIC | QLD | SA |
|--|------------------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Annie Bryson | <input type="checkbox"/> Brentwood | <input type="checkbox"/> Amaroo | <input type="checkbox"/> Elsternwick | <input type="checkbox"/> Bellevue |
| <input type="checkbox"/> Carmel | <input type="checkbox"/> Lee | <input type="checkbox"/> Fig Tree | <input type="checkbox"/> Macleod | <input type="checkbox"/> Parklands |
| <input type="checkbox"/> Dryandra | <input type="checkbox"/> Macleay | <input type="checkbox"/> Point | <input type="checkbox"/> Noble Park | <input type="checkbox"/> Lerwin |
| <input type="checkbox"/> Grandton | <input type="checkbox"/> Moyne | <input type="checkbox"/> Waterview | | |
| <input type="checkbox"/> Gwen Hardie | <input type="checkbox"/> Parkes | | | |
| <input type="checkbox"/> Sunshine Park | <input type="checkbox"/> Uralba | | | |

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 Intersex or Intermediate Not Stated/Inadequately described
 Female

I Describe Myself As: Male Female Lesbian Gay
 Bisexual Transsexual 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(This field is for historical reference only.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):

- | | |
|---|--|
| <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander origin | <input type="checkbox"/> Aboriginal but not Torres Strait Islander origin |
| <input type="checkbox"/> Torres Strait Islander but not Aboriginal origin | <input type="checkbox"/> Both Aboriginal and Torres Strait Islander origin |
| <input type="checkbox"/> Not stated/inadequately described | |

Country of Birth: _____ **Marital Status:** _____

Primary Language: _____ **Secondary Language:** _____

Religion: _____ **Currently Practicing:** Yes No

Partner's first/given name: _____

Partner's last name: _____

TYPE OF ACCOMMODATION REQUESTED

- | | | | |
|---|---|---------------------------------|---------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Large Single | <input type="checkbox"/> Double | <input type="checkbox"/> Shared |
| <input type="checkbox"/> Single Ensuite | <input type="checkbox"/> Single Shared Bathroom | | |

Please refer to individual sites for room option availability.
Medicare Number: _____ Card 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 form): _____

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 DECISION:

Consumer Enduring Power of Attorney Financial Administrator

“Original Documents” for Enduring Power of Attorney, or Financial Administrator are required to be provided at the time of admission.

PRIMARY CONTACT:

Primary contact Relationship: _____

First Name: _____ Last Name: _____

Address:

Country: _____ Street: _____

Suburb/Town: _____ State: _____ Postcode: _____

Primary Contact Telephone Numbers – Work: _____ Home: _____

Mobile: _____ Secondary Contact Email Address: _____

PERSON RESPONSIBLE FOR MEDICAL AND LIFESTYLE DECISION:

- Consumer Enduring Guardian Public Guardian Registered Supporter
 Enduring Power of Attorney (QLD, SA, VIC)

“Original documents supporting the above authorities are required to be provided at the time of admission.

PRIMARY CONTACT:

Primary Contact Relationship: _____

First Name: _____ Last Name: _____

Address:

Country: _____ Street: _____

Suburb/Town: _____ 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$ _____
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nominated Funeral Director: _____	
Address: _____	
Contact Number: _____	Service type: <input type="checkbox"/> Cremation <input type="checkbox"/> Burial
NAME OF FAMILY DOCTOR	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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. Infection prevention and control of Methicillin-resistant Staphylococcus aureus (MRSA) in Western Australian healthcare facilities. Perth, 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 of 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):
