

PLEASE COMPLETE FULLY & ANSWER QUESTIONS CLEARLY IN BLOCK LETTERS

Name of FACILITY that application relates to: Willandra (low care) [] Eltham Lodge (high care) [] ILU []

Surname: Given name(s):
 Home address:
 Postcode: Telephone: Email address:
 Date of birth:/...../..... Age: Place of birth:
 Marital status: Religion:.....
 Current address (if not home. e.g. hospital).....
 Department of Health & Ageing Client ID number:

PLEASE COMPLETE/ATTACH A COPY OF DOCUMENTATION FOR THE FOLLOWING ITEMS MARKED **

Referring Body: *Please attach the completed ACAS approval ***

Who is your nominated Primary Contact for dealings within the Residential Aged Care Facility?

Name: Telephone Number.....Email:.....

NEXT OF KIN: (Staple attachment if more than four)

NAME	RELATIONSHIP e.g. spouse, partner, son	ADDRESS	TELEPHONE (Home) (Bus.) (Mob.)	Email address
			(H) (B) (M)	
			(H) (B) (M)	
			(H) (B) (M)	
			(H) (B) (M)	

**** Who holds the Enduring POWER OF ATTORNEY: Financial Attached copy? YES/NO**

Name: Relationship:
 Telephone (Home): (Work): Email

**** Who holds the Enduring POWER OF ATTORNEY: Medical Treatment Attached copy? YES/NO**

Name: Relationship:
 Telephone: Bus Hrs.....After hrs..... Email

**** Is there a GUARDIANSHIP OR ADMINISTRATION ORDER in place? Attached copy? YES/NO**

Name: Relationship:
 Address: Post Code:
 Telephone: Bus Hrs.....After hrs..... Email

**** Is there a SOLICITOR nominated: YES/NO**

Name: Relationship:
 Address: Post Code:
 Telephone: Bus Hrs.....After hrs..... Email

**** Has a WILL been made? If so, please give details of the Executor(s): YES/NO**

Name: Relationship:
 Address:..... Post Code:
 Telephone: Bus Hrs.....After hrs..... Email

Current MEDICAL PRACTITIONER: Name:.....Telephone:

Address: Post Code:

**** Burial/Cremation arrangements: YES/NO**

Name/address Telephone Number.....

PRIVATE HEALTH INSURANCE: Fund: Table: Membership Number:

MEDICARE card number: Expiry date:.....

DVA Treatment Card: YES/NO Gold [] White [] Orange [] Card number:

Income and Assets

INCOME: TYPE OF PENSION [] AGE [] VETERAN [] DISABILITY [] OTHER
(Please Specify)

DO YOU RECEIVE A FULL/PART PENSION?

PENSION NUMBER(S): EXPIRY DATE:.....

FORTNIGHTLY RATE (A) (B)
(Age Pension) (Other)

DO YOU RECEIVE AN INCOME FROM SUPERANNUATION, OR RETIRING ALLOWANCE?

GIVE DETAILS OF AMOUNTS RECEIVED

IF ANY OTHER SOURCE OF INCOME, GIVE DETAILS, INCLUDING ANNUITIES, OR LIFE INTEREST IN HOUSE OR ESTATE YES/NO..... Please attach details where appropriate

HAVE YOU OWNED A HOUSE OR UNIT WITHIN THE LAST 2 YEARS?

IS YOUR SPOUSE, DEPENDENT FAMILY MEMBER or CARER STILL LIVING IN YOUR HOME?

ASSETS: All sections to be completed \$ INCOME FROM ASSETS (Per Annum)

HOME (Excluding Contents)

CONTENTS OF RESIDENCE

OTHER HOUSE OR LAND

CASH

SAVINGS: Bank, Building Society
Other

STOCKS AND/OR SHARES

BANK, BUILDING SOCIETY
OR OTHER TERM DEPOSIT

INSURANCE POLICIES,
MATURITY VALUE

BUSINESS

ANY OTHER ASSETS (e.g. loans to others)

LIABILITIES: (e.g. loans owing) \$

MORTGAGE TO BE REPAYED

BANK OVERDRAFT

LOANS TO BE REPAYED

ANY OTHER LIABILITIES

**** Ensure that a copy of the Centrelink or DVA 'Statement of Value of Assets' is attached.**

**** Ensure that a copy of the Centrelink or DVA 'Statement of Resident Status' is attached.**

NOMINATED PERSON RESPONSIBLE FOR PAYMENT OF FEES:

Name:
(Include address if not already on this form).....
Telephone: Bus Hrs.....After hrs.....Email
Relationship to Applicant

RESIDENT DECLARATION

I AGREE that, subject to my admission to the Residential Facility, I will observe the regulations of the Facility, and I will endeavour to live in harmony with my fellow residents, in accordance with the Rights and Responsibilities outlined in the Aged Care Act 1997. I also agree that the Management of the Facility in consultation with myself where-ever possible, my Medical adviser and/or any other subsequent parties, may transfer me to other accommodation, if it is considered that other care arrangements would be beneficial to me.

Applicant OR Authorised Representative name.....

Signature:.....Date.....

Name of Representative: Relationship (as per P.2)

Address.....

Telephone: Bus Hrs.....After hrs.....Email

SIGNATURE WITNESSED BY:

Address.....

Telephone: Bus Hrs.....After hrs.....Email

STATUTORY DECLARATION

I, (Full Name).....

Of (Current Address)

Do solemnly and sincerely declare that the information contained in this document is accurate in every particular AND

I acknowledge that this declaration is true and correct, and I make it with the understanding and belief that a person who makes a false declaration is liable to the penalties of perjury.

Declared at _____ this _____ day of _____ 20____
(town) (day in month) (month) (year)

By the said (signature) (sign in front of the authorised witness)

Before me: (signature of the authorised witness)

Name: Position:

Address:

OFFICE USE ONLY

DATE RECEIVED: DATE ASSESSED:

DATE OF ADMISSION:...../...../.....PRE-ENTRY LEAVE (if taken) from...../...../.....to/...../.....

LOCATION:UNIT/ROOM NUMBER:

RESIDENT STATUS Concessional: Assisted Supported

FORTNIGHTLY/MONTHLY FEE:

ACCOMMODATION BOND:ACCOMMODATION CHARGE:.....

CLASSIFICATION LEVEL at date of entry.....



Melbourne Citymission
Building Inclusive Communities

CONFIDENTIAL

Melbourne Citymission
Eltham Retirement Centre

Application for Permanent Admission

Direct Lines

WILLANDRA HOSTEL

Ph: 9430-1646

ELTHAM LODGE NURSING HOME

Ph: 9430-1601

ELTHAM INDEPENDENT LIVING UNITS

Ph: 9430-1635

Eltham Retirement Centre

Ph: 9431-0100

Fax: 9431-0342

43 Diamond Street

Eltham 3095

Email: agedcare@mcm.org.au

Website: www.mcm.org.au

Proposed Resident's Name: _____

Privacy Statement

Melbourne Citymission Services collects information when providing the following services:

Education, Employment & Training, Children Youth & Family Services, Aged Care, Disability Services, Palliative Care

Melbourne Citymission is required to adhere to the following Federal and State Legislation:

Privacy Amendment (Private Sector) Act 2000

Information Privacy Act 2000 (Victoria)

Health Records Act 2001 (Victoria)

In the course of providing our services, personal and sensitive information is collected, held and maintained by Melbourne Citymission. Your privacy is important to us and we are committed to protecting the information we collect, monitoring its use and maintaining its integrity. All information collected by Melbourne Citymission will be used only for the primary purpose intended. Where the intention includes confidentiality, the information will be retained as such, unless otherwise required by law. At times we are obliged to forward information to, or create reports for, other services or government departments. Disclosure of such information is in accordance with our written policies and limited to the intended purpose as agreed with Melbourne Citymission services. By law, you are generally entitled to access your personal information that we keep on record.

I consent to Melbourne Citymission forwarding information to other services and government departments as stated in the Privacy Act

.....
Signature **Date**
(Applicant or authorised representative)