MAYFIELD AGED CARE

ABN 32 002 360 152

Your Caring Home

APPLICATION FOR ADMISSION

PLEASE COMPLETE ALL QUESTIONS IN THIS FORM - IF THE ANSWER IS UNKNOWN EITHER WRITE **"UNKNOWN" OR "NOT APPLICABLE" IN THE SPACE PROVIDED**

PERSONAL DETAILS

Title: Mr... Mrs... Ms... Other (please specify): **Sex:** Male: Female: **Date Of Birth:**

Surname: **Given Names:** **Preferred Name:**

Country of Birth: **Languages Spoken:** **Religion:** **Weight:** **Height:**

If born overseas, date arrived in Australia: _____ Are you an Australian Citizen? Yes: No:

Marital Status: Single: Widowed: Married: Separated: De facto: Divorced: Unknown:

Residential address:

Telephone number: **Home:** **Mobile:** **Business:**

Income Status: Self-Funded: Full pension: Part pension: Workers' Compensation: Third Party:

DVA (type) Number: Colour Expiry Date: Other: (specify)

Pension Number: Expiry Date:

Medicare Number: Expiry Date: Number:

Health Fund Previous Pharmacy:

PBS Safety Net Number: Date Last Flu Vax: Date Last Pheumovax:

Diabetic: YES NO Allergies:

:

PERSON RESPONSIBLE & FAMILY DETAILS Who would be your 'person responsible'?

Title: Mr... Mrs... Ms... Other Name: Relationship to you:

Address Postcode:

Phone Numbers: Home: Business: Mobile:

Email: _____ Power of Attorney: YES NO Enduring Guardian: YES NO

Will the person responsible pay your accounts? Yes: No: If No, Please provide details below:

_____

IN THE EVENT OF EMERGENCY PLEASE CONTACT (An emergency is a significant change in the resident's medical condition)

Title: Mr... Mrs... Ms... Other Name: _____ Relationship to you: _____

Address: _____ Postcode: _____

Phone Numbers: Home: _____ Business: _____ Mobile: _____

Power of Attorney: YES NO Enduring Guardian: YES NO

Do you wish this person to be contacted at any hour of the day or night? Yes: No:

If no, between what hours do you wish to be contacted? Am _____ Pm_____

POWER OF ATTORNEY

Have you signed a Power of Attorney? Yes: No: Copy of Power of Attorney attached: Yes: No:
Name of person appointed under the Power Of Attorney: _____ Phone _____

GUARANTOR

1. Name:_____**Address**_____**Licence No**_____

2. Name:_____**Address**_____**Licence No**_____

GUARDIAN AND/OR FINANCIAL MANAGER

Have you appointed an Enduring Guardian or has a Guardian and/or Financial Manager been appointed? Yes: No:

If yes, copy of Appointment of Guardian or Guardianship and/or Financial Management Order attached: Yes: No:

If Guardianship or Financial Management Order made, date for review of order: _____

DETAILS OF NEXT OF KIN (is a person's closest living blood relative or relative by marriage / family).

Spouse (if same as 'person responsible' write "as above")

Title: Mr... Mrs... Ms... Name: Relationship to you:

Address: Postcode:

Phone: Home: Business: Mobile:

Email: Power of Attorney: YES NO Enduring Guardian: YES NO

CHILDREN OR OTHER CONTACT DETAILS

1st CONTACT Title: Mr... Mrs... Ms... Name: Relationship to you:

Address: Postcode**:**

Phone: Home: Business: Mobile:

Email: Power of Attorney: YES NO Enduring Guardian: YES NO

2nd CONTACT Title: Mr... Mrs... Ms... Name: Relationship to you:

Address Postcode:

Phone: Home: Business: Mobile:

Email: Power of Attorney: YES NO Enduring Guardian: YES NO

3rd CONTACT Title: Mr... Mrs... Ms... Name: Relationship to you:

Address: Postcode:

Phone: Home: Business: Mobile:

Email: Power of Attorney: YES NO Enduring Guardian: YES NO

OTHER DETAILS:

Are you currently residing in another Aged Care Facility? Yes: No:

If yes, name of Facility: Date of Admission:

DOCTORS:

General Practitioner: Phone: After Hours Phone:

Address Post Code:

FUNERAL ARRANGEMENTS

Funeral arrangements – provide details

The Executor/s under my Will is/are:

(This is for the purpose of refunding accommodation bond and other financial arrangements).

Title: Mr... Mrs... Ms... Name/s Phone:

Address: Post Code:

FINANCIAL INFORMATION:

Total amount of pension received (include Australian & foreign pensions): $_____ per fortnight

Total amount of taxable income from all sources (excluding pension) $ _____ per annum

Have you owned a home within the last two years? Yes: No:

If you still own a home, what is its market value? $_____

Do any of the following live in your home? **Spouse: Dependent Child: Carer: Close relative**:

Other

How long has this person/s been living in your home?

Does this person/s receives or is eligible to receive an income support payment? Yes: No:

Estimated total Means tested Fee (other than your home) owned or controlled by you directly or indirectly: $ _____

Would you like to order a Newspaper? **YES NO Name:** **Deliver:** Mon-Tues-Wed-Thurs-Fri

Clothing Labels are available to purchase, families are able to use the labeller which is available at Reception. We have an easy effective way to attach Labels to Clothing. **YES: NO:** Payment: Cash Account:

SIGNATURE AND DECLARATION

By signing this Application you declare that the information given in this form is true and complete, you give the Undertaking set out above in relation to change to any Power of Attorney and/or appointment of Guardian or Financial Manager and you provide the privacy consent set out above.

Date:

Signature of Applicant

If this Application is signed by an authorised signatory. (E.g. guardian, attorney, or person responsible).
Please insert name of signatory below and attach a copy of the relevant authorisation document.

Date:

Name of Authorised Signatory