Resident Application Form

Applicant Surname		**Given Names**	
Person Completing form:		**Application Date:**	

Thank you for applying for residency at a **Christadelphian Aged Care.** Please select the home below.

☐	**Ashburn House** 20-34 Ashburn Place, Gladesville NSW 2111	Ph: (02) 8876 9200
☐	**Courtlands** 15 Gloucester Ave, North Parramatta NSW 2151	Ph: (02) 9683 8000
☐	**Maranatha** 1582 Anzac Ave, Kallangur QLD 4503	Ph: (07) 3482 5333
☐	**Northcourt** 7 Saunders St, North Parramatta NSW 2151	Ph: (02) 9683 8000

INSTRUCTIONS:

The application must be completed by persons seeking permanent or respite residential aged care with Christadelphian Aged Care, or their enduring power of attorney or legal guardian.

All fields MUST be completed and returned to admissions@chomes.com.au otherwise a delay in processing the application may result. Enter "Not Applicable" for any fields where this applies.

Documents we require a copy of:
ACCR assessment completed by an Aged Care Assessment Team
Assets Assessment (Department of Social Services)
Documents for enduring power of attorney, enduring guardianship
Immunisation History Statement for Influenza and COVID Vaccination

To knowingly give false information in this document is an offence under the Act and will lead to the termination of your Resident Agreement.

This application does not imply an offer of residency; we will contact you if there is a prospect of entry.

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STATEMENT OF APPLICANT'S ASSETS AND INCOME

We require the following information to understand you have the financial capacity to pay for the accommodation being sought. You will also be required to complete a Combined Assets and Income Assessment Form (SA457) and submit this form to Centrelink (or the Department of Veterans' Affairs). This form is not compulsory to complete, **but if you choose not to you will be charged the maximum Means-Tested Care Fee**. You are encouraged to complete this in advance so the information is available when you come into care.

1. INCOME

Do you have a partner?	YES ☐ NO ☐ *(Please tick)*	if so, please enter combined numbers below

a. Payments from Centrelink or the Department of Veteran Affairs

Type of pension / payment	**Amount per fortnight $**

b. Other Income

Type of payment	**Amount per year $**
Interest from banks, building societies, credit unions	
Dividends and other investments	
Any other income	
Total gross income per year	

2. ASSETS

Do you own, or are you paying off, your home?	YES ☐ NO ☐			
Will a protected person live in the family home?	YES ☐ NO ☐		Evidence of PP status checked?	☐ Yes
PP Classification:	☐Spouse	☐ Dependent Child	☐ Carer with 2 yrs on ISP	☐ Other Family with 5 yrs on ISP

Type of Asset	**Market Value or Balance $**	
Real estate (Home) – Address:	$	
Real estate (Other) – Address:	$	
Financial assets - money in banks, building societies, credit unions	$	
Financial assets - shares, debentures, investments, life insurance policies	$	
Other assets - including vehicles, household goods, village contributions, RADs	$	
Total Assets	$	**A**

3. LIABILITIES

Type of Debt	**Balance $**	
Mortgage or overdraft debts	$	
Credit cards and other debts	$	
Total liabilities	$	**B**

NET ASSETS	***Total Assets (A) less Total Liabilities (B)***	$

To be signed by, or on behalf of, the applicant

I declare that the above information shown in the Statement of Assets, Income and Debts is correct.

Name:		Legal Capacity:	
Signature:		Date:	

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4. PERSONAL INFORMATION OF APPLICANT

First Name:	Middle Name:	Last Name:
Title:	Preferred Name:	Date of Birth: / /

Gender:	☐ Male	☐ Female	☐ Intersex	☐ Not Stated

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

Entry Type:	☐ Permanent	☐ Respite	Category:	☐ High	☐ Low	☐ Unclassified
Date Entered Facility: / /			☐ Permanent / ☐ Respite weeks			

Home Address:		
		Postcode
Currently Located:	**Facility Name / Details:**	**Contact Details:**
☐ Home	*address as above*	
☐ Hospital		
☐ Aged Care Facility		

Country of Birth		Religion	
Aboriginal: Yes ☐ No ☐		Torres Strait Islander: Yes ☐ No ☐	
Primary Language		Secondary Language	

Medicare Number		Member Number		Expiry Date:	/ /
Name on Medicare Card					
Pensioner	☐ Full	☐ Part	☐ Non-Pensioner	Centre Link / Pension Number:	
DVA No		DVA Card Colour:		Expiry Date:	/ /
Health Fund Name		Membership Number			
Funeral Director					

DETAILS OF THE APPLICANTS NOMINATED REPRESENTATIVES:

Primary Contact

Title		First Name		Last Name	
Contact Numbers	*(Home)*		*(Mobile)*		
Address					
Email					
Relationship to Applicant					
General correspondence is only sent to the Primary contact unless Secondary Contact is selected below*					
☐ Secondary Contact	**Please Note: invoices will be sent to the nominated Billing Address*				

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Secondary Contact

Title		First Name		Last Name	
Contact Numbers	*(Home)*		*(Mobile)*		
Address:					
Email					
Relationship to Applicant					

Responsible Person / Enduring Guardian Attach documentation as evidence to Application ☐

Title		First Name		Last Name	
Contact Numbers	*(Home)*		*(Mobile)*		
Address					
Email					
Relationship to Applicant					
Office use: If contact is Guardian / Enduring Guardian enter the applicable 'Contact Note' in iCare.					

Power of Attorney Attach documentation as evidence to Application ☐

Title		First Name		Last Name	
Contact Numbers	*(Telephone)*		*(Mobile)*		
Address					
Email					
Power of Attorney Type	☐ General	☐ Enduring	☐ Other – please specify		

Doctor (General Practitioner)

Title	DR	First Name		Last Name	
Contact Numbers	*(Work)*		*(Mobile)*		
	(After Hours)		*(Fax)*		
Address:					
Email					

Guarantor

Title		First Name		Last Name	
Contact Numbers	*(Home)*		*(Mobile)*		
Address					
Email					
Relationship to Applicant					
Billing Address details are the same as for Guarantor	☐ Yes	☐ *No (enter Billing address below)*			

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Billing Address

First Name		Last Name	
Phone Contact		Relationship to Applicant	
Email			
All invoices are sent electronically. Paper Statements attract an administration charge of $3.00 per statement.			
Address			

Current Pharmacy

Name		
Address		
Contact Numbers	*(Business)*	*(Mobile)*

Other Health Professional Details

Name		
Address		
Contact Numbers	*(Business)*	*(Mobile)*

Allergies			
Do you smoke?	☐ No	☐ Yes	If yes, how many daily: _____
Do you drink alcohol?	☐ No	☐ Yes	If yes, how often daily: ☐ Daily ☐ Weekly

Are you presently receiving Home Care services?	☐ No ☐ Yes
Provider Name:	
Date commenced Home Care Services?	Date: / /

Are you **presently** in a Residential Aged Care Facility?	☐ No	☐ Permanent	☐ Respite
Facility Name:	Date Entered	/ /	
Have you **ever resided** in a Residential Aged Care Facility?	☐ No	☐ Permanent	☐ Respite
Facility Name:	Date Entered	/ /	
Do you have an Aged Care Assessment Team approval for entry into aged care?	Yes ☐ No ☐		

Is this applicant ready for entry?	☐ Now ☐ Soon ☐ Future	Date: / /
Reasons for applicant's readiness:		

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COVID-19 TEST REQUEST
To protect all residents, we request all new admissions provide evidence of a COVID-19 test results in the last 72 hours (3 days). If being transferred from a hospital a test will be conducted post admission.

COVID-19 VACCINATION
The Australian Government has provided a protocol for new residents entering residential aged care in relation to vaccination for COVID-19 and available access to the vaccine. We wish to emphasise to all prospective residents the importance of getting vaccinated against COVID-19. Ideally new residents are fully vaccinated prior to admission. We request you complete details below so vaccination status is known for clinical care purposes.

Have you been vaccinated for COVID-19? (tick the correct response below)

☐ 4 DOSES	➢ Please provide a copy of your vaccination history when requested during the processing of your application.

☐ 1 Dose	➢ What is the date booked for your second vaccine?	**Date:**
	➢ Please provide a copy of your vaccination history when requested during the processing of your application.	

☐ No Doses	➢ Do you intend on having a COVID-19 vaccination?		
	☐ Yes	What date is your vaccine booked?	**Date:**
	☐ Maybe	If you have not had a discussion with your GP about having the vaccine, then we encourage you to do so and arrange immediately.	
	☐ No	Please review the additional information below and obtain medical advice in respect of your decision.	

Additional Details:

- Vaccination is voluntary, but strongly encouraged for all those living in residential aged care.
- Fact sheets about vaccination for residents and families are available here. https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines
- COVID-19 vaccination decision guide for frail older people, including those in residential aged care facilities (Version 2.1 30July21). The Department of Health will publish updated versions of this guide as more information and new vaccines become available (an information sheet is provided in the admission pack).

OFFICE USE ONLY:			
Date for COVID Test		**Test Confirmed as completed**	Sign / date
VACCINATION REVIEW (circle one option)		◯ Accepted	◯ Referred to CCO
Outcome of CCO referral			