

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.

<input type="checkbox"/>	Ashburn House 20-34 Ashburn Place, Gladesville NSW 2111	Ph: (02) 8876 9200
<input type="checkbox"/>	Courtlands 15 Gloucester Ave, North Parramatta NSW 2151	Ph: (02) 9683 8000
<input type="checkbox"/>	Maranatha 1582 Anzac Ave, Kallangur QLD 4503	Ph: (07) 3482 5333
<input type="checkbox"/>	Northcourt 7 Saunders St, North Parramatta NSW 2151	Ph: (02) 9683 6352

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.

RESIDENT APPLICATION FORM

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 <input type="checkbox"/> NO <input type="checkbox"/> <i>(Please tick)</i>	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	
Superannuation	
Any other income	
Total gross income per year	

2. ASSETS

Do you own, or are you paying off, your home?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
Will a protected person live in the family home?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Evidence of PP status checked? <input type="checkbox"/> Yes	
PP Classification:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> Carer with 2 yrs on ISP
			<input type="checkbox"/> 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	<i>Total Assets (A) less Total Liabilities (B)</i>	\$
-------------------	--	----

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:	

RESIDENT APPLICATION FORM

4. PERSONAL INFORMATION OF APPLICANT

First Name:			Middle Name:			Surname:		
Title:		Preferred Name:			Date of Birth:			
Gender:	<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Intersex		<input type="checkbox"/> Not Stated	
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> De facto	<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed	<input type="checkbox"/> Unknown	
Entry Type:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent – admit for palliative:	<input type="checkbox"/> Respite	<input type="checkbox"/> Convalescent Care				
		Palliative care status form received <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3					
Date Entered Facility:				<input type="checkbox"/> Permanent / <input type="checkbox"/> Respite				weeks
Departure date (for Respite Entry):								

Home Address:		
Postcode		
Currently Located:	Facility Name / Details:	Contact Details:
<input type="checkbox"/> Home	<i>address as above</i>	
<input type="checkbox"/> Hospital		
<input type="checkbox"/> Aged Care Facility		

Country of Birth		Religion	
Aboriginal: Yes <input type="checkbox"/> No <input type="checkbox"/>		Torres Strait Islander: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Primary Language		Secondary Language	

Medicare Number		Member Number		Expiry Date:	
Name on Medicare Card					
Pensioner	<input type="checkbox"/> Full	<input type="checkbox"/> Part	<input type="checkbox"/> Non-Pensioner	Centrelink / Pension Number:	Expiry Date:
DVA No	DVA Card Colour:				Expiry Date:
Health Fund Name		Membership Number			
Funeral Director					

RESIDENT APPLICATION FORM

DETAILS OF THE APPLICANTS NOMINATED REPRESENTATIVES:

Primary Contact

Title		First Name		Last Name	
Contact Numbers	<i>(Home)</i>			<i>(Mobile)</i>	
Address					Postcode:
Email					
Relationship to Applicant					
<i>General correspondence* is only sent to the Primary contact unless Secondary Contact is selected below</i>					
<input type="checkbox"/> Secondary Contact		<i>*Please Note: invoices will be sent to the nominated Billing Address</i>			

Secondary Contact

Title		First Name		Last Name	
Contact Numbers	<i>(Home)</i>			<i>(Mobile)</i>	
Address:					Postcode:
Email					
Relationship to Applicant					

Responsible Person / Enduring Guardian

Attach documentation as evidence to Application

Title		First Name		Last Name	
Contact Numbers	<i>(Home)</i>			<i>(Mobile)</i>	
Address					Postcode:
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	<i>(Telephone)</i>			<i>(Mobile)</i>	
Address					Postcode:
Email					
Power of Attorney Type	<input type="checkbox"/> General <input type="checkbox"/> Enduring <input type="checkbox"/> Other – please specify				

Doctor (General Practitioner)

Title	DR	First Name		Last Name	
Contact Numbers	<i>(Work)</i>			<i>(Mobile)</i>	
	<i>(After Hours)</i>			<i>(Fax)</i>	
Address:					Postcode:
Email					

RESIDENT APPLICATION FORM

Guarantor

Title		First Name		Last Name	
Contact Numbers		<i>(Home)</i>		<i>(Mobile)</i>	
Address				Postcode:	
Email					
Relationship to Applicant					
Billing Address details are the same as for Guarantor				<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(enter Billing address below)</i>	

Billing Address

First Name		Last Name	
Phone Contact		Relationship to Applicant	
Email			
<i>All invoices are sent electronically. Paper Statements attract an administration charge of \$3.00 per statement.</i>			
Address			Postcode:

Current Pharmacy

Name			
Address			Postcode:
Contact Numbers	<i>(Business)</i>	<i>(Mobile)</i>	
Safety Net Number			

Other Health Professional Details

Name			
Address			Postcode:
Contact Numbers	<i>(Business)</i>	<i>(Mobile)</i>	

Allergies			
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many daily: _____	
Do you drink alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how often daily: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly	

Are you presently receiving Home Care services?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Provider Name:			
Date commenced Home Care Services?		Date:	
Contact Details of Provider:		Copy of full fees Statement received:	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

RESIDENT APPLICATION FORM

Are you presently in a Residential Aged Care Facility?	<input type="checkbox"/> No	<input type="checkbox"/> Permanent	<input type="checkbox"/> Respite
Facility Name:	Date Entered:		
	Departure Date (Respite):		
Have you ever resided in a Residential Aged Care Facility?	<input type="checkbox"/> No	<input type="checkbox"/> Permanent	<input type="checkbox"/> Respite
Facility Name:	Date Entered:		
	Departure Date:		
Do you have an Aged Care Assessment Team approval for entry into aged care?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this applicant ready for entry?	<input type="checkbox"/> Now	<input type="checkbox"/> Soon	<input type="checkbox"/> Future
	Date:		
Reasons for applicant's readiness:			

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)

<input type="checkbox"/> Doses	➤ Please provide a copy of your vaccination history when requested during the processing of your application.
--------------------------------	---

<input type="checkbox"/> No Doses	➤ Do you intend on having a COVID-19 vaccination?		
	<input type="checkbox"/> Yes	What date is your vaccine booked?	Date:
	<input type="checkbox"/> 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.	
	<input type="checkbox"/> 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).