ROSEWOOD
welcome home

ROSEWOOD CARE GROUP INC

APPLICATION FOR ADMISSION

Form RA 01

(Strictly Confidential Data)

THIS FORM MUST BE COMPLETED PRIOR TO AGREEMENT BEING ENTERED INTO

Date of Permanent Admission: _____

Date of Respite Admission Period from: _____ to: _____

Facility: WEST PERTH LEEDERVILLE EITHER (Please circle)	
Surname:	Title:
First Name:	Preferred Name:
Date of Birth:	Country of Birth:
Gender:	Marital Status:
Nationality	Language spoken:

Current GP:		Phone No:	
Facility GP:		Name on Electoral roll ☐ Yes ☐ No	
ACAT assessed:		Copy Attached: ☐	
Date:	Team:	Social Worker:	Phone
Pension No:		Type:	Expires
Please circle: Full / Part / Non-Pensioner / DVA : ☐ Gold ☐ White ☐Orange			
Medicare No./Ref:		Expiry Date:	
Name of Health Fund:			
Membership Number:			
Type of Cover: Hospital / Ancillary / Ambulance			
Safety Net Entitlement No:			
Ambulance Fund Membership No:		Expiry date	

Next of Kin / Contact in case of Emergency:	Relationship:
Name:	Title
Address:	
Home Phone:	
Email:	Mobile Phone:

2nd Contact in case of Emergency:	Relationship:
Name:	Title
Address:	
Home Phone:	
Email:	Mobile Phone

Preferred Funeral Service Provider: Burial / Cremation (please circle)

Name of Person responsible for Accounts:	
Billing Address:	
Legal information (Appointed Guardian, Power of Attorney, Executor etc, Advanced Health Directive) Attach copy	
Completed by:	**Date:**
Where did you hear about us?	

INITIAL ENTRY MEDICAL INFORMATION SHEET

Name of Resident:		Room No:

Could you please assist us by providing any relevant medical information (not already included on the ACCR).
(For example ulcers, recurring infections, previous medical conditions, swallowing difficulties, memory loss)

.....

.....

.....

Allergies:

Please tick appropriate ✓

Communication Memory loss /Confusion: ☐ Yes ☐ No	Glasses ☐ Yes ☐ No Hearing aid (s) ☐ Yes ☐ No
Nutrition: Normal diet ☐ Diabetic ☐ Other: ☐..... Special Precautions/needs/allergies:.....	
Incontinence: ☐ Yes ☐ No	Uses pads: ☐ Yes ☐ No Type of pad: .....
Constipation ☐ Yes ☐ No	Aperient required: ☐ Yes ☐ No Type of aperient: .....
Assistance with toileting: ☐ Yes ☐ No	Requires reminding: ☐ Yes ☐ No

Mobility: Totally independent / Uses aids / Requires assistance / Totally dependent

Aids used: Walking stick / Quad stick / Frame / Wheelchair / Other (*please specify)*

Hygiene: Showers daily ☐ Yes 2nd Daily ☐ Yes
Special requirements: .....

Dental Care: Own teeth: ☐ Yes ☐ No Dentures ☐ Yes ☐ No
Assistance required: .....

Sleep Routine: Usual retiring time: ..... Generally sleeps well ☐ Yes ☐ No
Other needs: (eg no. of pillows, night light, sedation etc) .....

Smoking status: ☐ Current smoker ☐ Ex-smoker ☐ Non-smoker, never smoked

Medical equipment required: Oxygen / Nebuliser / Concentrator / Other (*please specify)*

Special instructions: Wound dressing / Podiatrist / Naturopath / Physio etc.
- please specify and attach relevant reports

Other relevant information: for example pain management concerns, wandering, emotional needs, spiritual and social support needs.

APPROVED BY: ..... DATE: .....
(SIGNATURE OF RN/CNM/EMCS)

APPLICATION FOR PERMANENT RESIDENTIAL CARE

The following information is in addition to Pages 1 and 2 to help us gather information to provide you with the most appropriate accommodation within the correct room status category

A current ACCR (Aged Care Client Record, formerly known as an ACAT Assessment) is required before entering into our Facility.

ACCR completed:	☐ Yes ☐ No
If No – Do you need assistance to initiate an ACCR?	☐ Yes ☐ No
Copy of ACCR attached:	☐ Yes ☐ No

Present Accommodation Address:
.....
.....
.....

Is your family aware of your application:	☐ Yes ☐ No
Have you had Respite at any other Facility, if so when and for how long?	
.....	

Consent

Please indicate (✓) your consent to be photographed for the below purposes:

☐ Publicity / Media Stories	☐ Internal Resident Photo Montages
☐ Rosewood's Social Media Sites	☐ Internal Newsletters
☐ I do not authorise any photos to be published	

Please indicate (✓) your preference for your family members' mail received at Rosewood.

☐ Resident to receive personal mail.

☐ Resident to receive legal and financial mail.

☐ Please redirect legal and financial mail to:

Name: .....

Address: .....

Assets, Income & Liability Summary

Please note
Applicants who have joint accounts, assets or liabilities only write their share on this form – NOT the total amount.

Name of Resident:	

Has an Asset and Income Assessment been submitted to the Department of Human Services?	☐ Yes ☐ No
If Yes, copy attached	☐ Yes ☐ No

1. Australian Pension

Do you receive the Centrelink pension?	☐ Yes ☐ No
If Yes, please tick type	☐ Full ☐ Part
Do you receive a Department of Veterans Affairs pension?	☐ Yes ☐ No
If Yes, what colour card issued:	☐ White ☐ Gold ☐ Orange
Fortnightly amount received:	$ _____
Are you recognised by the Department of Veterans Affairs as a POW?	

2. Overseas and Other Pensions

Please give details (type and amount) of other pensions received for example overseas pensions.	
Details	**Amount**

3. Other Incomes

Do you receive any other income not mentioned in 1 or 2 above?	☐ Yes ☐ No
Source	Net average weekly income $
Rent	
Interest	
Dividends (excl. franked credits)	
Insurance policy/friendly society etc.	
Dividends/distributions/bonuses	
Business profits	
Other income	
Total	$

Total average weekly other income means total average weekly income, assessable for tax purposes (excluding imputation credits attaching to franked divided income), net of expense deductible for tax purposes, receivable from all sources except for Centrelink Aged Pensions, Department of Veterans' Affairs pensions and, in both cases, rental assistance and pharmaceutical allowances paid as supplements to those pensions.

4. Home Ownership Status

Have you owned a home in the last 2 years? If yes please provide property address:	☐ Yes ☐ No
Has your spouse/dependant child/carer or close relative been living in the home for 5 years?	☐ Yes ☐ No
Is your spouse/dependant child/carer or close relative eligible for any pension or benefit?	☐ Yes ☐ No

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Private and Confidential

5. Financial Details

Assets	$	Liabilities	$
Value of home (excluding contents)		Mortgages to be repaid	
Household contents and effects ie furniture, white goods		Other mortgages	
Other real estate			
Cash in hand			
Savings Account/s			
Cheque Account/s			
Shares, notes, units in trust etc.		Loans etc.	
Insurance policies (maturity value)		Bank overdraft etc.	
Businesses			
Any other assets ie car, paintings, collectables		Any other liabilities	
Total		Total	

RESPITE BOOKING FEE – Respite Residents Only

A booking fee (equivalent to 1 weeks respite accommodation) is to be paid on the date of booking. The booking fee is a prepayment of respite care fees and not an extra payment.

Please note:
If you cancel the Respite Care booking more than 7 days before the Agreed Occupancy Date, We will refund you the Booking Fee.

If you cancel the Respite Care booking within 7 days of the Agreed Occupancy Date and the reason for cancellation is not that you have been admitted to hospital, we will retain the Booking Fee.

If you decide to leave the Care Facility before the end of the Term, we can retain from the Booking Fee, the whole or part of the Care Fee for the unused period of the Term.

The information I have declared in this form is, to the best of my knowledge, true and correct in all material respects.

Dated: .....

Signature: ..... *(Resident or Legal Representative)*

Print Name: .....

In the presence of: ..... *(Witness Name)*

Address of Witness: .....

Witness signature: .....

Please complete and return to Administration, Rosewood Care Head Office, PO Box 136 Mount Hawthorn WA 6915