

APPLICATION FOR ADMISSION

Form RA 01

Leederville

West Perth

First Name:	Surname:
Date of Birth:	Gender:
Country of Birth:	Marital Status:
Nationality:	Language Spoken:
Address:	
Home Phone:	Mobile:

Current GP:	GP Phone No:
Facility GP:	Name on Electoral roll <input type="checkbox"/> Yes <input type="checkbox"/> No
ACAT assessed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Copy Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral Codes:	Referral Codes:

Pension Number: _____	Expiry Date: _____
Pension Type: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Non-Pensioner	DVA : <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Orange
Other funding sources: <input type="checkbox"/> NDIS <input type="checkbox"/> Other (please specify):	
Medicare Number:	Expiry Date:

Name of Health Fund:	Membership Number:
Type of Cover: <input type="checkbox"/> Hospital <input type="checkbox"/> Ancillary <input type="checkbox"/> Ambulance	
Safety Net Entitlement No:	
Ambulance Fund Membership No:	Expiry date:

Next of kin:	Relationship: <input type="checkbox"/> Enduring Guardianship <input type="checkbox"/> Enduring Power of Attorney
Name:	
Address:	
Mobile Phone:	
Home Phone:	
Email:	

2nd Contact in case of Emergency:	Relationship: <input type="checkbox"/> Enduring Guardianship <input type="checkbox"/> Enduring Power of Attorney
Name:	
Address:	
Mobile Phone:	
Home Phone:	
Email:	

Preferred Funeral Service Provider Name:	
Address / Suburb:	Phone No:
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation	Special Requirements:

Name of Person Responsible for Accounts:	
Billing Address:	
<input type="checkbox"/> Enduring Guardianship <input type="checkbox"/> Enduring Power of Attorney <input type="checkbox"/> Executor <input type="checkbox"/> Advanced Health Directive	
Completed by:	Date:
Where did you hear about us?	

Admissions Clinical Care Needs

This information will assist us in determining your current health care requirements to ensure that we can provide you with safe and high-quality care.

Have you been in hospital for more than one night in 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require assistance with eating or drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any special dietary requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any falls in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require any aids to help you mobilise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had the 2021 Influenza vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had the Covid19 vaccination? <i>(Please provide certificate of immunisation if available)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine Name: <i>(e.g. Pfizer)</i>
	Dose 1 date received:
	Dose 2 date received:
Please select if any of the following is applicable	
<input type="checkbox"/> Dementia <input type="checkbox"/> Cancer Treatment <input type="checkbox"/> Heart Problems <input type="checkbox"/> More than 100kgs <input type="checkbox"/> Wandering <input type="checkbox"/> Depression <input type="checkbox"/> Immobile <input type="checkbox"/> Non- verbal <input type="checkbox"/> Refusal of Care <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Aggression <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Smoker <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Memory Problems <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Pain <input type="checkbox"/> Wounds	
Any special requests or preferences we should consider?	

Consent and Mail Redirection

Any other family members who require email communications/ updates/ bulletins from Rosewood	
Name:	Email:
Name:	Email:

Present Accommodation Address

Is your family aware of your application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had Respite at any other Facility, if so when and for how long?	

Mail Redirection

Please indicate (✓) your preference	
<input type="checkbox"/>	Resident to receive personal mail.
<input type="checkbox"/>	Resident to receive legal and financial mail.
<input type="checkbox"/>	Please redirect legal and financial mail to:
Name:	
Address:	

Photography Consent

Please indicate (✓) your consent to be photographed for the below purposes:			
<input type="checkbox"/>	Publicity / Media Stories	<input type="checkbox"/>	Internal Resident Photo Montages
<input type="checkbox"/>	Rosewood's Social Media Sites	<input type="checkbox"/>	Internal Newsletters
<input type="checkbox"/>	I do not authorise any photos to be published		

Assets, Income & Liability Information

Please note

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

Name of Resident:	
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Has an Asset and Income Assessment been submitted to Services Australia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is there a copy attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. Australian Pension

Do you receive the Centrelink pension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please tick type	<input type="checkbox"/> Full <input type="checkbox"/> Part
Do you receive a Department of Veterans Affairs pension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, what colour card issued:	<input type="checkbox"/> White <input type="checkbox"/> Gold <input type="checkbox"/> Orange <input type="checkbox"/> No
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

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3. Other Incomes

Do you receive any other income not mentioned in 1 or 2 above?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your spouse/dependant child/carer or close relative been living in the home for 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your spouse/dependant child/carer or close relative eligible for any pension or benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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5. Financial Details

Assets	\$	Liabilities	\$
Value of home		Mortgages to be repaid	
Household contents and effects		Other mortgages	
Other real estate			
Cash in hand			
Savings Account/s			
Cheque Account/s			
Superannuation			
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	

RESPIRE 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