**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 🞏 Yes 🞏 No |
| ACAT assessed: 🞏 Yes 🞏 No | Copy Attached: 🞏 Yes 🞏 No |
| Referral Codes: | Referral Codes: |

|  |  |  |
| --- | --- | --- |
| Pension Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Expiry Date: \_\_\_\_\_\_\_\_\_ |
| Pension Type: 🞏 Full 🞏 Part 🞏Non-Pensioner | DVA : 🞏 Gold 🞏 White 🞏Orange | |
| Other funding sources: 🞏 NDIS 🞏 Other (please specify): | | |
| Medicare Number: | | 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:** | Relationship: 🞏Enduring Guardianship 🞏 Enduring Power of Attorney | | | |
| Name: | | | | |
| Address: | | | | |
| Mobile Phone: | | | | |
| Home Phone: | | | | |
| Email: | | | | |
|  | | | | |
| **2nd Contact in case of Emergency:** | Relationship:\_\_\_\_\_\_\_\_\_\_ 🞏Enduring Guardianship 🞏 Enduring Power of Attorney | | | |
| Name: | | | | |
| Address: | | | | |
| Mobile Phone | | | | |
| Home Phone: | | | | |
| Email: | | | | |
|  | | | | |
| **Preferred Funeral Service Provider Name:** | | | | |
| Address / Suburb: | | | Phone No: | |
| 🞏 Burial 🞏 Cremation | | Special Requirements: | | |

|  |  |
| --- | --- |
| Name of Person Responsible for Accounts: | |
| Billing Address: | |
| 🞏Enduring Guardianship 🞏 Enduring Power of Attorney 🞏 Executor 🞏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? | | | 🞎 Yes 🞎 No | |
| Do you require assistance with eating or drinking? | | | 🞎 Yes 🞎 No | |
| Do you have any special dietary requirements? | | | 🞎 Yes 🞎 No | |
| Have you had any falls in the last 3 months? | | | 🞎 Yes 🞎 No | |
| Do you require any aids to help you mobilise? | | | 🞎 Yes 🞎 No | |
| Have you had the 2022 Influenza vaccination? | | | 🞎 Yes 🞎 No | |
| Have you had the Covid19 vaccination?  *(Please provide certificate of immunisation if available)* | | | 🞎 Yes 🞎 No  Vaccine Name:  *(e.g., Pfizer)* | |
| Dose 1 date received: | |
| Dose 2 date received: | |
| Dose 3 date received: | |
| Dose 4 date received: | |
| Please select if any of the following is applicable | | | | |
| 🞎 Dementia  🞎 Wandering  🞎 Refusal of Care  🞎 Aggression  🞎 Memory Problems | 🞎 Cancer Treatment  🞎 Depression  🞎 Diabetes  🞎 Bowel Incontinence  🞎 Urinary Incontinence | 🞎 Heart Problems  🞎 Immobile  🞎 Infection  🞎 Smoker  🞎 Pain | | 🞎 More than 100kgs  🞎 Non- verbal  🞎 Vision Impaired  🞎 Hearing Impaired  🞎 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? | 🞏 Yes 🞏 No |
| Have you had Respite at any other Facility, if so when and for how long? | |

Mail Redirection

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Please indicate (✓) your preference | | |  | Resident to receive personal mail. | |  | Resident to receive legal and financial mail. | |  | Please redirect legal and financial mail to: | |
| Name: |
| Address: |

Photography 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 | | |
|  |  | | | |

**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:** |  |

|  |  |
| --- | --- |
| Has an Asset and Income Assessment been submitted to Services Australia? | 🞏 Yes 🞏 No |
| If Yes, is there a 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 🞏 No |
| Fortnightly amount received: | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you recognised by the Department of Veterans Affairs as a POW? |  |

1. **Overseas and Other Pensions**

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

**APPLICATION FOR PERMANENT RESIDENTIAL CARE**

***Private and Confidential***

1. **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.

1. **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 |

**APPLICATION FOR PERMANENT RESIDENTIAL CARE**

***Private and Confidential***

1. **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** |  |

**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