ROSEWOOD
welcome home

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	☐ Cancer Treatment	☐ Heart Problems	☐ More than 100kgs
☐ Wandering	☐ Depression	☐ Immobile	☐ Non- verbal
☐ Refusal of Care	☐ Diabetes	☐ Infection	☐ Vision Impaired
☐ Aggression	☐ Bowel Incontinence	☐ Smoker	☐ Hearing Impaired
☐ Memory Problems	☐ Urinary Incontinence	☐ Pain	☐ 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?	

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

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	

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