The Good Shepherd Home
EXCEPTIONAL CARE

CARE APPLICATION

For Respite or Permanent Care

Please Indicate:

- (•) Application for Permanent Care Position
- ( ) Application for Respite Care Only
- ( ) Respite and Application for Permanent Care Position

Check List - Have you Attached:

- ☐ Copy of Aged Care Assessment / My Support Plan
- ☐ Current Health Summary supplied by your Doctor
- ☐ Copy of Residential Aged Care Fees Letter including attachment of Assets Summary
- ☐ Enduring Power of Attorney
- ☐ Completed Statement of Choices **A** or **B** OR Advanced Health Directive
- ☐ Copy of Home Care Client Balance Statement (if applicable)

OFFICE USE ONLY

Applicant's Name: _____ Date Received: _____

PERSONAL DETAILS

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Miss

First Name: _____ Middle Name: _____

Last Name: _____ Preferred Name: _____

Gender: ◯ Male ◯ Female Date of Birth: _____/_____/_____

Marital Status: ◯ Married ◯ Divorced ◯ De Facto
◯ Single ◯ Widowed ◯ Unknown

Home Address: _____

_____ Postcode: _____

Postal Address: (*If different to home address*) _____

_____ Postcode: _____

Email Address: _____

Contact Phone: Primary: _____ Alternate: _____

Religion: _____ Aboriginal or Torres Strait Origin: ◯ Yes ◯ No

Please advise of any cultural or religious requirements, such as specific dietary needs._____

_____

Country of Birth: _____ Language(s) Spoken: _____

Do you need an interpreter to help with your everyday English: ◯ Yes ◯ No

Nominated Representative:

If you would like The Home to contact a representative on your behalf about this application or placement, please provide details below. If you are nominating a person who has legal authority to make decisions for you, please advise the type of authority they have, and attach a copy of the authority to this application.

First Name:_____ Last Name: _____

Postal Address: _____

_____ Postcode: _____

Contact Phone: Primary: _____ Alternate: _____

Mobile: _____ Email Contact: _____

Relationship to you: _____

Type of Authority: _____

The Good Shepherd Home
EXCEPTIONAL CARE

Next of Kin (first contact): (If same as nominated representative, write 'as above')

First Name:_____ Last Name: _____

Postal Address: _____

_____ Postcode: _____

Contact Phone: Primary: _____ Alternate: _____

Mobile: _____ Email Contact:_____

Relationship to you: _____

Next of Kin (second contact):

First Name:_____ Last Name: _____

Postal Address: _____

_____ Postcode: _____

Contact Phone: Primary: _____ Alternate: _____

Mobile: _____ Email Contact: _____

Relationship to you: _____

OTHER DETAILS

Medicare Details

Your name as it appears on the card: _____

Card Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Exp. Date: _____

The number that appears at the left of your name i.e. 1, 2: _____

Diabetes Number if applicable (NDSS): _____

Pension Details:

Do you receive a pension?

- ◯ **Yes**, I receive a full pension
- ◯ **Yes**, I receive a part pension
- ◯ **No**, I do not receive a pension

If yes, which do you receive:

- ☐ **Centrelink payment**
- ☐ **Department Veterans' Affairs payment**

Pension Card Number ☐☐☐ ☐☐☐ ☐☐☐☐ Exp. Date: _____

If you receive a Department Veterans' Affairs pension what colour is your card: _____

The Good Shepherd Home
EXCEPTIONAL CARE

Private Health Insurance Details

Name of Fund: _____ Membership No: _____

Level of cover: _____ Exp Date: _____

Funeral Preferences: ◯ Burial ◯ Cremation ◯ Undecided

Funeral Preferences details e.g. Funeral director etc: _____

_____

_____

Medical Contact Details

General Practitioner: _____

Address: _____

Contact No: _____ Mobile: _____

Fax Number: _____ Email: _____

Other Health Professional: _____

Field i.e. Audiologist, heart specialist: _____

Chemist: _____

Safety Net: _____ Allergies: _____

Diagnosis: _____

Thank you for your application.
Please contact our Resident Services Team
for any further information
07 4772 9900