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 or Referral Code:___-_____
☐ Current Health Summary supplied by your Doctor
☐ Copy of Estimated Aged Care Fees (Centrelink)
☐ Enduring Power of Attorney (Certified Copy)
☐ Completed Statement of Choices **A** or **B** OR Advanced Health Directive
☐ Copy of Medicare Card, Pension/DVA Card (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: _____

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: _____

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: _____