Application for Permanent / Respite Admission to Indigo North Health Residential Aged Care Facility

Indigo North Health inc

168 High Street, RUTHERGLEN VIC 3685
Phone: 60336200 Fax: 02 60329133
ABN 24 413 439 986 Inc No. A00051746G
Email: inh@inh.org.au

Are you applying for:

☐ Permanent Entry **OR** ☐ Respite Care

Applicant Details (please print in block letters) * mandatory fields – must be completed

Title (Mr, Mrs, Miss etc)	
***Last Name**	
***First Name(s)**	
Preferred Name	
***Date of Birth**	/ /
Present Address	
	State **Post Code**

MY AGED CARE INFORMATION

Have you been assessed by the Aged Care Assessment Team as requiring residential care?	☐ **No** ☐ **Yes** **Date of Assessment:** / /
My Aged Care – Referral Number (Respite)	
My Aged Care – Referral Number (Permanent Care)	

PENSION / MEDICARE INFORMATION

***Medicare Card Number.**	
Pensioner Concession Card	
Department of Veteran Affairs Card No. (if applicable)	
Ambulance Subscriber No.	
Commonwealth Medical Services Entitlement No	
Please provide the date of your last Flu Immunisation.	

If you need an interpreter to help with everyday English, please write the language you speak here:

Please advise of any cultural, religious or other organisations that you would like to remain in contact with.

Please advise whether you have cultural or religious requirements, such as special dietary needs

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Applicant Personal Contacts:

Authorised Representative: (if any) e.g enduring power of attorney, guardian			
Full Name			
Address			
Phone Nos	**Business**	**Private**	**Mobile**
Email:			
Relationship			
Next of Kin:			
Full Name **Address**			
Phone Nos	**Business**	**Private**	**Mobile**
Relationship			

General Practitioner :	
Name :	**Telephone No:**
Email:	**Fax:**
Would you prefer your GP continue to visit you while you reside at "Glenview"	**Yes / No** Please circle

Responsibility for Paying Accounts and Receiving Correspondence

Do you wish to be responsible for receiving correspondence from Indigo North Health Inc., including accounts, once you have accepted a place?

- ☐ **Yes I would like to receive my correspondence; or**
- ☐ **No, I would like my nominated representative to receive my correspondence;**

Name of Representative:____

When do you wish to take up residence at Indigo North Health? ___________
____

Signature of Applicant✍: ..______________________ **Date:** _____/_____/_____

Note: The information collected on this form is for the purpose of your application, and is not disclosed for any other purpose. It is stored with your records in the administration office.

Office Use Only

☐ **Application on eCase**

UR NO: ______________