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.

Are you applying for: ☐ Permanent Entry **or** ☐ Respite Care

APPLICANT INFORMATION

Name: _____ _____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Other _____

Home Address: _____

Applicant Phone Number: _____

Language(s) spoken in the home: _____ Cultural Background: _____

Any special considerations eg: cultural, religious beliefs or other organisations that you would like to remain in contact with? _____

_____

Are you of Aboriginal and/or Torres Strait Islander origin? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal and Torres Strait Islander ☐ No

Are you on the Electoral Roll? ☐ Yes ☐ No

MY AGED CARE INFORMATION

Have you been assessed by the Aged Care Assessment Team as requiring residential care? ☐ Yes ☐ No

If yes, Date of Assessment: / /

My Aged Care – Referral Number (Respite) _____

My Aged Care – Referral Number (Permanent Care) _____

HEALTH INFORMATION

Medicare Card No:_____ Reference No._____ Exp Date:_____

Pensioner / Concession Card number: _____ Exp Date:_____

Department of Veterans Affairs : ☐ No ☐ Yes Card No:_____

Private Health Fund: ☐ No ☐ Yes Fund Name: _____Member No._____

Ambulance Subscriber No (if applicable) _____

Name Doctor/Medical service:_____Telephone:_____

Doctors Address:_____

Date of your last Flu immunisation: ___/___/_____ Date of your last COVID immunisation ___/___/_____

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A copy of your Immunisation History Statement from the Australian Immunisation Register

This can be obtained from:

- The Express Plus Medicare mobile app
- The Australian Immunisation Register via My Gov - Medicare - Proof of vaccinations or My Gov - My Health Record - Immunisation History Statement
- Or you receive a written copy by calling the Australian Immunisation Record on 1800 653 809 Mon- Fri 8am - 5pm

Do you have any allergies or intolerances to food or Medication? If yes, please give details:_____

_____

AUTHORISED REPRESENTATIVE (if any) e.g. enduring power of attorney, guardian

Family Name: _____ Given Names: _____

Address: _____

Phone no: Mobile: _____ Private:_____Business:_____

Email: _____

NEXT OF KIN

Family Name: _____ Given Names: _____

Address: _____

Phone no: Mobile: _____ Private:_____Business:_____

Email: _____

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 leecare** UR NO: _____