APPLICATION FOR PERMANENT AND RESPITE ADMISSIONS

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

1. APPLICANT DETAILS

Name _____ **Title** ◯ Mr. ◯ Mrs. ◯ Ms ◯ Other _____

Date of Birth _____ **Gender** ◯ Male ◯ Female ◯ Other _____

Current Address _____

Email _____ **Phone** _____

Nationality _____ **Country of Birth** _____

Interpreter Required ◯ Yes ◯ No **Language Spoken** _____

Aboriginal or Torres Strait Islander Origin?

◯ Yes, Aboriginal ◯ Yes, Torres Strait Islander ◯ Yes. Aboriginal &Torres Strait Islander

◯ No

Religion _____ **Are you on the electoral roll?** ◯ Yes ◯ No

Medicare No ☐☐☐☐ - ☐☐☐☐☐ - ☐

Reference ☐ **Expiry Date** ☐☐ - ☐☐

Is the applicant a pensioner? ◯ DVA ◯ Full Pensioner ◯ Part Pensioner ◯ No (Self Funded)

Pension Card Number _____ Expiry _____

Private Health Insurance ◯ Yes ◯ No Provider name _____ Member No _____

Ambulance Subscriber No. (If applicable) _____

Current Doctor Name / Medical Service _____

Telephone _____ **Address** _____

Date of your last Flu immunisation _____

Date of your last Covid immunisation _____

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

_____

2. CONTACTS

AUTHORISED REPRESENTATIVE (If any)

Power of Attorney type ◯ Financial ◯ Medical

Full Name _____ Relationship to Applicant _____

Address _____ Postcode _____

Contact Phone _____ Mobile _____

Email _____

PRIMARY CONTACT (IN CASE OF EMERENCY)

Full Name _____

Relationship to applicant _____

Contact Phone _____

Mobile _____

Email _____

SECONDARY CONTACT (IN CASE OF EMERGENCY)

Full name _____

Relationship to Applicant _____

Contact Phone _____

Mobile _____

Email _____

3. RESPONSIBILITY FOR PAYING ACCOUNTS AND RECEIVING CORRESPONDENCE

Do you wish to be responsible for receiving correspondence from Glenview Health, 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 Glenview Health?

Permanent Care: _____

Respite Care _____

Glenview Health

4. MY AGED CARE INFORMATION

Respite Stay

◯ High Level Care ◯ Low Level Care ◯ Unfunded ◯ Funded by third party

ACAS Approval Date _____ **My Aged Care Referral Code** -_____

Permanent Stay

◯ Non supported ◯ Partially Supported ◯ Fully Supported

ACAS Approval Date _____ **My Aged Care Referral Code** -_____

Please confirm the above details are correct. ◯ Yes ◯ No

Signature _____ **Date** _____

5. OFFICE USE ONLY

Respite

Respite Admission Date _____ **Respite Departure Date** _____

Respite Days Available _____

Repeat Respite Admission (date) _____

Please confirm the above details remain unchanged ◯ Yes ◯ No

Repeat Respite Admission (date) _____

Please confirm the above details remain unchanged ◯ Yes ◯ No

Repeat Respite Admission (date) _____

Please confirm the above details remain unchanged ◯ Yes ◯ No

Permanent Care

1. Has the resident transferred from another provider ◯ Yes ◯ No
2. Has an income and asset test been submitted to Centrelink? ◯ Yes ◯ No
3. Is the resident electing not to submit their income and asset assessment? ◯ Yes ◯ No

Transfer from Respite to Permanent (date) _____