



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: _____



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

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: _____

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): _____



Home Care

Are you / have you ever received Home Care services?

No

Yes – please provide balance of Income Tested Care Fees paid (Balance Statement)

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: _____

Do you have an Advance Health Directive or Statement of Choices Form **A** or Form **B**:

Yes No (If YES please supply a copy with this application)

Please give details of any ALLERGIES: _____

Medical Contact Details

General Practitioner: _____

Address: _____

Contact No: _____ Mobile: _____

Other Health Professional: _____

Field i.e. Audiologist, heart specialist: _____

Chemist: _____



Please indicate the type of accommodation you require:

- Concessional/Assisted Resident (Assets under \$168,351.20) Effective 20th March 2019.
- \$275,000 RAD or equivalent
- \$300,000 RAD or equivalent
- \$325,000 RAD or equivalent
- \$400,000 RAD or equivalent
- \$410,000 RAD or equivalent
- \$470,000 RAD or equivalent

- Are you interested in our Extra Services Accommodation?** *(Please note our Extra Services Accommodation requires a minimum RAD amount of \$410,000 - \$470,000 and additional daily fees)*

IMPORTANT PLEASE:

- **Attach** a copy of your current Aged Care Assessment approval / My Support Plan
- **Attach** a current health Summary supplied by your Doctor.
- **Attach** a copy of Residential Aged Care Fees Letter including attachment of Assets Summary
- **Attach** a copy of Enduring Power of Attorney
- **Attach** one of the following:
 - Advanced Health Directive
 - Statement of Choices Form **A** or Form **B**
- **Attach** a copy of Home Care Client Balance Statement (if applicable)

Name: _____ **Date:** ____/____/____