EXPRESSION OF INTEREST FOR RESIDENTIAL AGED CARE

This form must be completed by people wishing to be considered for Permanent and Respite Residential Aged Care

Are you applying for Respite ☐ **or** **Permanent Placement?** ☐

Has ACAS been completed **Yes** **No** **(circle correct answer)**

If Yes, please provide a copy of the Services Australia letter with the individual's approval codes

Has an Income and Assets Assessment been completed? **Yes** **No**

If No, please see Unit Manager

Personal Details:

Title (Mr, Mrs, Miss etc.) ☐

Last Name ☐

First Name(s) (Legal) ☐

Preferred Name ☐

Gender ☐ Male Female ☐ Other ☐ Indeterminate ☐

Do you identify as an Aboriginal or Torres Strait Islander? Yes ◯ No ◯

Date of Birth ☐

Marital Status ☐

Home Address ☐

☐ Postcode

Admitted From: Hospital ☐ Home: ☐ Other: ☐

Do you receive Full Pension or Part Pension? ☐

Name on Pension Card ☐

Pension Card Number ☐ Expiry ☐

Name on Medicare Card ☐

Medicare Number ☐ Expiry ☐

Name on DVA Card

DVA Number Expiry

Private Health Fund Expiry

Medical Practitioner of choice

Name:

Clinic Address:

Please list Allergies:

Medications:

Food:

Others:

Does the individual have any prescribed medication? Yes: No:

NB: Cohuna District Hospital Residential Aged Care utilises an electronic medication management system and multi dose sachets. These incur a small fee each week, which is added to the Pharmacy Account.

Religion:

Country of Birth: **Main Language**:

Contact Details

1st Contact

Last Name

First Name

Address

Contact Numbers

AH BH

Mobile

Email

Relationship

2nd Contact

Last Name

First Name

Address

Contact Numbers

AH BH

Mobile

Email

Relationship

Person Responsible for Fees and Charges:

Name: Relationship:

Address:

Post Code:

Contact Numbers

AH BH

Mobile

Email

Has the individual appointed any of the following alternative decision makers?

Power of Attorney –Enduring Financial? **Yes** **No** **If Yes Please attach**

Name of Power of Attorney:

Address:

Phone:

Medical Treatment Decision Maker? **Yes** **No** **If Yes Please attach**

Name of Medical Treatment Decision Maker:

Address:

Phone:

Restricitve Practices Substitute Decision Maker (RPSDM) **Yes** **No**

(this person may be the Medical Treatment Decision Maker, but must be able to be contacted to make emergency decisions if required.)

Name of Restrictive Practices Substitute Decision Maker:

Address:

Phone:

If **Yes** to any of the above, please attach a copy If **No** please see staff for information on how to complete one

Does the applicant have an Advanced care Directive **Yes** ☐ **No** ☐ If **No** please see staff for information on how to complete one

Reason for application

Please give a brief description of reasons why you are seeking to be placed on the Residential Aged Care Waiting List

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_____

Signature of person completing the form

_____

Date _____

Relationship to applicant

_____

Please return form to
Director of Clinical Services
PO Box 317 Cohuna 3568
mibibby@cdh.vic.gov.au