RESIDENTAL AGED CARE APPLICATION

The information requested in this application will enable Villa Dalmacia To assess your care and accommodation needs. Please fill in the underline space or tick the appropriate box. If you would like assistance of further information on completing this application, please contact Administration on 9418 5222.

Upon receipt of the completed Application form and ACAT assessment, you will be duly contacted to confirm that we have received your application and invite you to tour the facility if not already done so.

VILLA DALMACIA
AGED CARE SERVICES

Do you have an Aged Care Assessment Team (ACAT) form completed? Yes ☐ No ☐

To apply for entry to an Aged Care Facility you MUST have a completed ACAT assessment form. A copy of the completed assessment form must be attached to this application form.

Centerlink or Department of Veterans Affairs Pension No:_____

Overseas Pension No, (if applicable):_____

Please Circle: Full Pension Part Pension Non Pension

Medicare No:_____ Expiry Date:_____ Ref:_____

PERSONAL DETAILS:

TITLE (Mr, Mrs, Ms, Miss):_____ Surname:_____

Maiden Name:_____ First Name:_____

Date of Birth:_____ Marital Status:_____

Nationality:_____ Preferred Language: (please specify)_____

Current Address:_____

Post Code:_____ Phone No:_____

Next of Kin (If possible, please list two)

1. Name:_____ Relationship:_____

Address:_____

Post Code:_____ Phone No:_____

Email:_____

1. Name:_____ Relationship:_____

Address:_____

Post Code:_____ Phone No:_____

Email:_____

PERSONAL DETAILS (continued):

Do you manage your own financial affairs: Yes ☐ No ☐

If Not, who manages your financial affairs:

Name:_____ Relationship:_____

Address:_____

Post Code:_____ Phone No:_____

Email:_____

Have you given anyone Power of Attorney (PA)? Yes ☐ No ☐

Have you given anyone Enduring Power of Attorney (EPA)? Yes ☐ No ☐

Have you given anyone Enduring Power of Guardianship? Yes ☐ No ☐

If yes: Name:_____ Relationship:_____

Address:_____

Post Code:_____ Phone No:_____

Email:_____

** Please attach Copy

Do you have private health Insurance? Yes ☐ No ☐

Name of Insurance company:_____ Member Number:_____

St John Ambulance No:_____ Expiry Date:_____

PBS Safety Net Card:_____

Do you have a will? Yes ☐ No ☐

Held by?_____ Relationship:_____

Address:_____

Phone No:_____

Have you made any funeral arrangements? Yes ☐ No ☐

If so Who? Name:_____

Address:_____

Phone:_____

Type of Funeral: Burial ☐ Cremation ☐

Religion:_____

YOUR PERSONAL CARE NEEDS

Who is your current Doctor?_____

Medical Practise?_____ Phone:_____

Is your Doctor prepared to continue to care for you if you move to Villa Dalmacia Aged Care: Yes ☐ No ☐

Medical Conditions: (eg. Current Diagnosis, Diabetic etc):_____

_____

_____

_____

_____

Allergies:_____

_____

Can you manage your own mediations? Yes ☐ No ☐

Any comment:_____

_____

WALKING: independent ☐ with aid ☐ assisted/supervised ☐ full assistance ☐

walking stick ☐ quad stick ☐ splints ☐ wheelchair ☐

gutter frames ☐ frame ☐ Wheelie walker ☐

Are these aids owned by you? Yes ☐ No ☐

The aids are in loan from:_____

DRESSING Independent ☐ Assisted/Supervised ☐ Fully Assisted ☐

UNDRESSING: Independent ☐ Assisted/Supervised ☐ Fully Assisted ☐

USUAL TIME FOR BED _____

EATING/DRINKING: Independent ☐ Assisted/Supervised ☐ Fully Assisted ☐

Other ☐_____

Special dietary requirements Medical YES ☐ No ☐

Religious YES ☐ No ☐

Cultural YES ☐ No ☐

Details:_____

Do you have difficulty in swallowing? YES ☐ No ☐ Details:_____

_____

TOILETING: Independent ☐ Assisted/Supervised ☐ Fully Assisted ☐

Do you experience incontinence? YES ☐ NO ☐

Do you have problems with:

Bladder Control: Always ☐ Usually ☐ Occasionally ☐ Never ☐

Bowel Control: Always ☐ Usually ☐ Occasionally ☐ Never ☐

Do you use incontinent aids? (ie pads) Yes ☐ No ☐ During the Day ☐ At Night ☐

Catheter: YES ☐ NO ☐

PERSONAL SUPPORT NEEDS *(please tick appropriate box)*

Do you experience:	YES	NO	How do you deal with these problems?
Poor Vision			
Poor Hearing			
Communication difficulties			
Poor memory			
Anxiety			
Fear			
Frustration / Anger			
Sadness			
Getting Lost			

Other:
(describe)_____

_____

_____

PERSONAL SOCIAL HISTORY:

What activities/interests do you enjoy?_____

_____

_____

_____

_____

_____

_____

Where do you currently live?:

Own Home	☐	Hostel	☐
Nursing Home	☐	Hospital	☐
Other	☐	Waiting for a placement	☐

If other please describe:

_____

If Aged Care Facility (ie hostel): Name of the facility:_____

Type of Accommodation Required: Secure ☐ Non Secure ☐

An applicant requires secure accommodation if they wander or exhibit behaviour that will impinge on the quality of like of others.

CHECK LIST:

1. ☐ Have you enclosed your ACAT/ MY AGED CARE SUPPORT PLAN form?
2. ☐ Have you completed all section of this form that are relevant to you?
3. ☐ Have you enclosed a copy of your Centre Link Assessment?

APPLICANT'S SIGNATURE: _____

Date of Application:_____

Name and signature of the person who completed this form *(IF DIFFERENT FROM APPLICANT*)

Name:_____

Relationship to Applicatant:_____

Signature:_____

Date of Application:_____

Thank you

VILLA DALMACIA
AGED CARE SERVICES

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Spearwood WA 6163
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Fax: 08 9434 1755
Email: info@villadalmacia.com.au