L_M Fin Fm 2o

RESIDENTIAL AGED CARE APPLICATION

Before completing this form, please read through the "Information Pack" provided under "Full Care Accommodation" on the Wintringham website: www.wintringham.org.au.

Please tick the residential aged care option you would like to apply for:

PERMANENT CARE

☐ McLean Lodge Flemington	☐ Port Melbourne Hostel	☐ Williamstown Hostel
☐ Ron Conn Avondale Heights	☐ Eunice Seddon Dandenong	☐ Gilgunya Village Coburg

RESPITE

☐ Eunice Seddon Dandenong	☐ Williamstown Hostel

1. APPLICANT DETAILS

SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH
(DD/MM/YYYY) _____/_____/_____ COUNTRY OF BIRTH _____

GENDER _____COMMENTS _____

☐ SINGLE ☐ PARTNERED/MARRIED

☐ OTHER _____ COMMENTS_____

ADDRESS _____

_____POSTCODE _____

CONTACT ( )_____ MOBILE_____

EMAIL _____

2. ARE YOU CURRENTLY A WINTRINGHAM CLIENT?

☐ Yes ☐ No

(ie. Are you currently residing in Wintringham Housing and/or receiving a home care package or support services through Wintringham?)

If yes, please select program:

☐ Home Care Package/Case Manager
☐ Wintringham Housing Support Worker
☐ Residing in Wintringham Housing
☐ Supported Residential Services (Angus Martin House)

Office: _____ (eg. Northern, Western office)

3. REFERRAL SERVICE

☐ **SELF Go to next question** ☐ **OTHER Continue:**

NAME: _____
RELATIONSHIP: _____
ORGANISATION: _____
ADDRESS: _____
_____ POSTCODE: _____
TELEPHONE: ( ) _____ MOBILE _____
EMAIL: _____

4. GUARDIANSHIP

☐ **Medical** ☐ **Accommodation** ☐ **Other** ☐ **No Guardian Appointed**

If no guardian has been appointed, please proceed to next question.

NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
_____ POSTCODE_____
TELEPHONE ( )_____ MOBILE _____
EMAIL: _____

5. NEXT OF KIN

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____POSTCODE_____

TELEPHONE ( )_____ MOBILE _____

EMAIL: _____

6. POWER OF ATTORNEY

Appointed Power of Attorney? ☐ **Yes** ☐ **No**

If no, please proceed to next question.

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____POSTCODE_____

TELEPHONE: ( )_____ MOBILE _____

EMAIL: _____

(Please provide a copy as evidence of your appointed Power of Attorney)

7. ADMINISTRATOR DETAILS

Appointed Administrator? ☐ **Yes** ☐ **No**

If no, please proceed to next question.

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____POSTCODE_____

TELEPHONE: ( )_____ MOBILE _____

EMAIL: _____

8. FINANCIAL MANAGMENT

- SELF ☐
- POWER OF ATTORNEY ☐
- ADMINISTRATOR (eg. State Trustees) ☐

9. FINANCIAL INFORMATION

☐	Centrelink: Aged	☐	Department of Veteran Affairs: Service pension
☐	Centrelink: Disability	☐	Department of Veteran Affairs + T&PI
☐	Centrelink: Other	☐	Superannuation
☐	Overseas Pension	☐	Other _____ Please specify

PENSION NUMBER: _____

10. BILL TO

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____POSTCODE_____

TELEPHONE ( )_____ MOBILE _____

EMAIL: _____

11. CURRENT HOUSING

Are you currently homeless or at risk of becoming homeless?

☐ **Yes** ☐ **No**

If yes, how long have you been homeless for? _____

Please select current housing:

	Crisis Accommodation		Own Home
	Hospital		Private Rental
	Community Housing		Private Hotel
	Rooming House		Street/Car
	Aged Care Facility		Transitional Care Program (TCP)
	Public Housing		Wintringham Housing
	Supported Residential Services (SRS)		Other:_____

Name of Facility or Organisation: _____

12. AGED CARE ASSESSMENT SERVICES (ACAS) APPROVAL

Have you been approved by an aged care assessment service for Respite and/or Permanent Residential Aged Care?

☐ Yes ☐ No

If yes, please provide your My Aged Care respite and/or permanent residential aged care referral codes to Wintringham- Advice and Information.

Email: adviceandinfo@wintringham.org.au
Fax: (03) 9376 8138

If you have not received an aged care assessment please contact My Aged Care on:
Ph. 1800 200 422

13. NATIONAL DISABILITY INSURANCE SCHEME (NDIS) APPROVAL

Have you been approved to receive an NDIS support plan?

☐ Yes ☐ No ☐ Unsure ☐ N/A

Has your plan commenced?

☐ Yes ☐ No

Commencement date: _____

Provider name: _____

14. HEALTH INFORMATION

DOCTOR: _____

ADDRESS: _____

_____POSTCODE_____

TELEPHONE: ( )_____MOBILE _____

EMAIL: _____

MEDICARE NO. _____

PRIVATE HEALTH INSURANCE

☐ Yes ☐ No

15. SERVICES

Please tick the boxes for the services that are currently received by the applicant:

- Home Help eg. assistance with cleaning & laundry ☐
- Meal Services eg. Meals on Wheels ☐
- Personal Care eg. Help with hygiene, medication etc. ☐
- Home Nursing Service ☐
- Shopping ☐
- Transport ☐
- Assistance with Financial matters ☐
- Social support and activities ☐
- Other (please specify): _____ ☐
  _____ ☐

16. CULTURALLY AND LINGUISTALLY DIVERSE BACKGROUND

Linguistically diverse background: ☐ Yes ☐ No

Language spoken at home: _____

Would you like us to use an interpreter when speaking with you?

☐ Yes ☐ No

If you only want an interpreter present during specific conversations, please list what those instances are:

_____

17. OTHER INFORMATION

ADVANCED CARE PLAN ☐ Yes ☐ No
If Yes, please provide a copy.

FUNERAL PLAN ☐ Yes ☐ No

If Yes, Name of Funeral Director _____

CURRENT LEGAL WILL ☐ Yes ☐ No

If Yes, where is the Will held? _____

Do you have a Pet ☐ Yes ☐ No

(Pet care requirements must be discussed with Site Manager)

18. GENERAL

(Please tick the appropriate columns)

DO you need any help with the following:	Please tick to indicate how much help do you need			
	No help	Help to set up	Supervision	Assistance
Eating				
Transferring				
Walking				
Dressing/Undressing				
Washing and Drying				
Grooming (Shaving, Hair, Teeth)				
Using Toilet				
Toilet Hygiene (hand washing, dressing)				

Do you	Yes	No	Unsure	Comments
Ever have any incontinence?				
Forget things?				
Follow instructions easily?				
Ever wander and get lost?				
Ever get angry?				
Ever get frustrated?				
Suffer from depression?				
Take any regular medication?				
Take medication more than once per day?				
Drink alcohol every day?				
Have any problems taking medication?				
Need injections for anything (e.g. Insulin)?				
Use an allied health provider (e.g. podiatrist, physiotherapist, RDNS)?				
Need blood pressure monitoring (more than weekly)				
Need blood sugar levels taken				
Need pain medication				
Need pressure area care				
Need special feeding (what type)				
Need catheter care				
Need wound care				
Wear compression stockings				
Need oxygen therapy				
Have a stoma				
Need tracheostomy care				

19. Do you have additional support needs?

_____

_____

_____

_____

_____

_____

_____

20. SIGNATURE

APPLICANT or
REPRESENTATIVE: _____

PRINT NAME: _____

DATE: ____/____/____

Please note

- All information provided to Wintringham will remain confidential and is needed to assess the applicants suitability for Residential Aged Care
- The purpose of the Application Form is to identify prospective residents. It does not constitute any agreement by Wintringham to provide services.

Admin use only Date Application Received: