

# Application for Accommodation Form

PH: 1800 722 522

Level 8, 9 Help Street, Chatswood, NSW 2067



## Thank you for choosing Scalabrini.

To add your name to our waiting list, please complete this application form and hit the SUBMIT button. You will also need to email or fax your recent ACAT assessment and all relevant medical information.

**F: 02 8876 6860 | E: accommodation@scalabrini.com.au**

## APPLICANT DETAILS:

Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Mr  Mrs  Miss

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Current Address: \_\_\_\_\_

Do you have an ACAT approval for entry into Residential Aged Care?  Yes  No

Marital Status:  Single  Married  Widowed

Moving from:  Home  Hospital  Other Aged Care Home  Other (Please specify): \_\_\_\_\_

If arriving from hospital; date of original entry to hospital: \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Nationality: \_\_\_\_\_

Medicare No: \_\_\_\_\_ Medicare Card Expiry Date: \_\_\_\_\_

Medicare Card Member No: \_\_\_\_\_

Name as it appears on Medicare card: \_\_\_\_\_

Private Health Fund Name: \_\_\_\_\_ Private Health Fund No: \_\_\_\_\_

Pension No: \_\_\_\_\_  Full  Part  None

Pension Card Expiry Date: \_\_\_\_\_ DVA No: \_\_\_\_\_

Do you have a Power of Attorney?  Yes (attach copy if available)  No

Name: \_\_\_\_\_

Do you have an Enduring Power of Attorney?  Yes (attach copy if available)  No

Name: \_\_\_\_\_

Do you have an Enduring Guardian?  Yes (attach copy if available)  No

Name: \_\_\_\_\_

Do you have an Advance Care Plan or Directive?  Yes (attach copy if available)  No

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## PERSON RESPONSIBLE 1:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Authority to Make Decisions:  Yes  No

If yes, the type of authority held (please attach a copy): \_\_\_\_\_

## PERSON RESPONSIBLE 2:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Authority to Make Decisions:  Yes  No

If yes, the type of authority held (please attach a copy): \_\_\_\_\_

Mail to be sent to:  Applicant  Person Responsible (1)  Person Responsible (2)

Do you authorise us to speak with these persons regarding possible accommodation if we are unable to contact you directly?  Yes  No

## The following information will assist in calculating the correct fees and charges.

Have you submitted an application for Residential Aged Care Assets and Income Assessment through Centrelink or the Department of Veterans' Affairs?  Yes  No

If you currently live within a residential aged care service, please provide details of any agreed accommodation payment arrangements.

Do you live alone?  Yes  No

Do you own your current home?  Yes  No

Are you a  Self Funded Retiree  Part Pensioner  Full Pensioner

Will someone remain living in the family home when you move into Scalabrini?  Yes  No

Please provide an estimate of the value of your current assets: \_\_\_\_\_

Please provide an estimate of your income per annum: \_\_\_\_\_

Is there any other information which you may believe is relevant to your financial circumstances? e.g. DVA pensioner, housing commission tenant, overseas pension recipient etc. \_\_\_\_\_

## PERSON COMPLETING THIS FORM:

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

How did you hear about Scalabrini? \_\_\_\_\_

**SUBMIT**