

RESIDENTIAL AGED CARE ENQUIRY FORM

Please circle the assessment that applies to the applicant **My Aged Care** or **ACAT** or **No Assessment**

Please provide **My Age Care** referral code for

| | | | | | | | | | | | | |
|-----------------------|---|--|--|--|--|--|--|--|--|--|--|--|
| Residential Permanent | - | | | | | | | | | | | |
| Residential Respite | - | | | | | | | | | | | |

or

Please provide **ACAT Assessment**

Resident personal details

| | | | |
|------------------|-------|----------------|--|
| Preferred name | _____ | | |
| Surname | _____ | Given Names | _____ |
| Date of Birth | _____ | Marital Status | Never married/ Defacto/ Married/ Widowed |
| Country of Birth | _____ | Main Language | _____ |
| Address | _____ | | |
| Postcode | _____ | Mobile | _____ |
| Telephone Bus | _____ | After Hours | _____ |

Pension details

| | | | | |
|-----------------|--|-------------|-------|-------------|
| Pension Status | Full / Part / Assisted / Concessional / Non / C/Link / DVA (please circle) | | | |
| Pension Number | _____ | Pension Exp | _____ | |
| DVA Number | _____ | Colour | _____ | |
| Medicare Number | _____ | Position No | _____ | Expiry Date |
| | | | _____ | _____ |

Medical practitioner

| | | | |
|----------|-------|----------|-------|
| Name | _____ | Practice | _____ |
| Address | _____ | | |
| Postcode | _____ | Phone | _____ |

Resident personal care details (please circle)

Height _____ft/cm Weight _____kgs Smoker Y / N

Driving Yes / No Will this continue when entering residential aged care Yes / No

Walking Independent Supervised Assisted Full Assisted With Aid

Aids Used Walking Stick Walker Motorised Nil

Other _____

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Resident personal care details continued (please circle)

| | | | | |
|----------------------------|-------------|------------|----------|---------------|
| Dressing/Undressing | Independent | Supervised | Assisted | Full assisted |
| Showering | Independent | Supervised | Assisted | Full assisted |
| Toileting | Independent | Supervised | Assisted | Full assisted |
| Incontinence | Yes / No | | | |
| Eating/Drinking | Independent | Supervised | Assisted | Full assisted |

Special dietary requirements due to (please circle)

| | | | | | |
|----------------------------|----------|-----------|-------------------|--------------|--------------------|
| | Cultural | Religious | Allergy | Nut | Lactose intolerant |
| | Medical | Vegan | Coeliac | Egg | Gluten free |
| Please specify | _____ | | | | |
| Other allergies | _____ | | | | |
| Alcohol consumption | Yes / No | | | | |
| Please specify | 1 Glass | 2 Glasses | 3 Glasses or more | | |
| Frequency | Daily | Weekly | Monthly | Occasionally | |

Resident nominated representative

| | | | |
|--------------------------------|-----------------------------|---------------------|---------------------------|
| Name | _____ | Relationship | _____ |
| Address | _____ | | |
| Postcode | _____ | Mobile | _____ |
| Telephone Bus | _____ | After Hours | _____ |
| Representative capacity | | | |
| Please circle | Financial Power of Attorney | Guarantor | Medical Power of Attorney |

Please note that you will be required to supply the above original or certified documents that support the "Representative Capacity" that is circled

Please Note:

- Faversham House is a **NON SMOKING** Facility. Residents are not permitted to smoke in our buildings or grounds.
- Faversham House does not permit **MOTORISED MOBILITY AIDS** (i.e. Scooters, Wheelchairs) within the Facility.
- Adhering to Coroners' ruling **BED POLES** are not permitted at Faversham House.

This section to be completed for PERMANENT residents only

RESIDENT STATEMENT OF ASSETS, DEBTS AND INCOME

Note: *If you have a partner, then only half of the value listed below will be considered.*

Please note that when applying for **Permanent Residential Aged Care**, you will be required to complete a Combined Asset and Income Assessment with Centrelink.

| Asset Type | Value |
|--|-------|
| Your Home (Value is capped) | \$ |
| Net Retirement Village Entry Contribution (Refundable balance) | \$ |
| Accommodation Bond or RAD to be refunded | \$ |
| Financial Accounts(e.g. Bank accounts, Term Deposits) | \$ |
| Shares(Listed and Unlisted) | \$ |
| Managed Investments | \$ |
| Assessable Streams (e.g. allocated Pensions and Annuities) | \$ |
| All Foreign Assets | \$ |
| Real Estate and Business Interests | \$ |
| Private Trusts and Private Companies | \$ |
| Gifts/Deprivation (Over the allowable limit) | \$ |
| Other Assets (e.g. motor vehicles, life insurance, household furniture and personal effects) | \$ |
| Debts | Value |
| Personal Loans | \$ |
| Other Debts | \$ |
| Asset Reduction Amounts | Value |
| Prisoner of War Compensation Amounts | \$ |
| Income | Value |
| Government Income Support Payments | \$ |
| Other Income (e.g. Income from work, compensation, rental income) | \$ |

NAME _____ RESIDENT SIGNATURE _____

OR

REPRESENTATIVE NAME _____ REPRESENTATIVE SIGNATURE _____