Outlook Gardens

Application Form for Aged Care Facilitity

Please mail completed form and any correspondence to:
The Residential Services Manager
Outlook Gardens Aged Care Facility
504 Police Rd, North Dandenong. Vic. 3175
Phone: 9795 7566. Fax: 9795 2088

The details completed on this form must be true and correct in every respect.

Outlook Gardens Aged Care Facility is collecting the information on this form for the purpose of processing your application and assessing the level of residential and medical care appropriate to your needs.

The information relating to your current state of health and financial status will be disclosed to the Commonwealth Government as this is a requirement under the *Aged Care Act.* It will be used to make decisions about the level of funding that you will be entitled to receive.

The other information collected on this form will not be disclosed to any individual or organisation without your consent. If you would like to know more about privacy at Outlook Gardens Aged Care Facility, including your right to seek access to any of the information collected on this form than you may contact the General Manager on 9795 7566.

Personal Details

Surname:		Given Names:	
Address:			
Home Phone No:		Mobile No:	
Email Address:			
Sex		Male ☐ Female ☐	
Date of Birth:		Country of Birth:	
Preferred Language:			
Do you speak English:		Yes ☐ No ☐	
Marital Status:	Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced ☐		
Occupation before retirement:			

Religion (Denomination):	
Church Affiliation (Congregation):	
Name of Minister/ Priest:	
Address:	
Phone No:	

Medicare Details

Full name as on Medicare card (Please check card for correct details)	

Medicare Number
Please enter the 10 digit Medicare number and the individual reference number (IRN). The IRN is the number to the left of the name of the Medicare card

										IRN	

Details of Spouse (If applicable)

Name:	
Address:	
Home Phone No:	
Is your spouse also applying for accommodation in this Aged Care Facility? Yes ☐ No ☐	
If no, will your spouse remain at present address? Yes ☐ No ☐	
New Address of Spouse (if applicable)	

Details of Children

Name of 1st contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

Name of 2nd contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

Name of 3rd contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

Name of 4th contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

If you have no children, or if you here so nominate, the following will be contacted to take responsibility for your affairs if and when necessary. Please give details of two persons

Name of 1st contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

Name of 2nd contact:			
Address:			
Home Phone No:		Business No:	
Email Address:		Mobile No:	

Details of Present Accommodation

Are you living by yourself?	Yes ☐ No ☐
Are you living with relatives or friends?	Yes ☐ No ☐
Are you living in a Retirement Village?	Yes ☐ No ☐
Do you currently own your own residence?	Yes ☐ No ☐

Physical Condition

Can you walk without an aid?	Yes ☐ No ☐
If no specify what you are using:	

Can you dress/undress yourself?	Yes ☐ No ☐
Can you shower independently?	Yes ☐ No ☐
Can you use the toilet by yourself?	Yes ☐ No ☐
Can you eat without assistance?	Yes ☐ No ☐
Can you look after your own medication?	Yes ☐ No ☐

Do you have special dietary requirements?	Yes ☐ No ☐
If yes, please specify:	
Describe your health	Good ☐ Fair ☐ Poor ☐

Do you suffer from any disability, eg arthritis, blindness etc?	Yes ☐ No
If yes, please specify:	
If applicable please list any history you have in regard to infectious diseases:	
Are you having regular medical treatment for an ongoing condition	Yes ☐ No ☐

Dentist Details

Name:	
Address:	
Phone No:	
When did you last attend a dentist?	

Do you have Dentures: Partial ☐ Whole ☐ Comments:
All dentures need to be marked for identification before admittance. It is recommended that a visit to the dentist is arranged prior to admission for assessment and treatment and any oral care needs are advised to us

Doctors Details

Name:	
Address:	
Phone No:	
Fax No:	
Email Address:	

Have you been assessed by an Aged Assessment Team Yes ☐ No ☐
If yes please provide a photocopy of your current Assessment If no please arrange for an assessment and send a photocopy to us to enable us to place you on our waiting list.

Any other details you may wish to mention	

Power of Attorney Details

Name:	
Address:	
Phone No:	
Email Address:	

Financial Information

Please provide the following information:

Current value of house if applicable: (Or value of home if disposed of in the last 2 years).	$
Current balance in all financial institutions: E.g. banks, building societies	$
Other investments: (Bonds, debentures, shares)	$
Value of other assets including car:	$
List any debs including mortgages:	$

This application must be signed by the prospective resident of the Outlook Gardens Aged Care Facility, except in cases where applicant suffers from Senile Dementia or Alzheimer's disease, in which cases the appointed Power of Attorney should sign.

Signed:		Dated:	