

# Application for Admission



Thank you for your interest in joining the Embleton Care family. Please ensure this form is fully completed to ensure that you are eligible for entry into our facility.

### Mandatory assessments:

ACAT assessment attached? Yes  No

Centrelink Assessment attached? Yes  No

Comment if not attached: \_\_\_\_\_

Applicants are unable to join the waitlist until both the ACAT and Centrelink Assessments are provided to Embleton Care Facility unless the applicant declares the resident as non-subsidised in the above comments.

### Resident's Details

Resident's Surname: \_\_\_\_\_

Resident's given names: \_\_\_\_\_

Resident's preferred name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Gender: Male  Female

Country of birth: \_\_\_\_\_

Primary language: \_\_\_\_\_

Other languages: \_\_\_\_\_

Is an interpreter required? Yes  No

Marriage / partnership status: \_\_\_\_\_

Religion / Belief: \_\_\_\_\_

Currently practicing? Yes  No

Is resident on electoral role? Yes  No

If yes, do they want to stay on role? Yes  No

Medicare number: \_\_\_\_\_ Expiry: \_\_\_\_\_

Private health insurance: Insurer: \_\_\_\_\_

Membership number: \_\_\_\_\_

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Pension status: Full:  Part:  Non-pensioner:

DVA / Centrelink Number: \_\_\_\_\_

Diabetic Card Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

Taxi Vouchers on Hand Yes  No

If no, would you like them? Yes  No

Nominated funeral director: \_\_\_\_\_

Contact number: \_\_\_\_\_

Service type: Cremation  Burial  Other

### **Next of Kin's Details**

**Primary** next of kin's name: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

Address of next of kin: \_\_\_\_\_

Contact number (home): \_\_\_\_\_

Contact number (work): \_\_\_\_\_

Contact number (mobile): \_\_\_\_\_

Email address: \_\_\_\_\_

**Secondary** next of kin's name: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

Address of next of kin: \_\_\_\_\_

Contact number (home): \_\_\_\_\_

Contact number (work): \_\_\_\_\_

Contact number (mobile): \_\_\_\_\_

Email address: \_\_\_\_\_

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### **Guardianship Details**

Trustee / Guardianship: \_\_\_\_\_

Power of Attorney (Enduring): \_\_\_\_\_

Power of Attorney (General): \_\_\_\_\_

### **Billing Details**

Person responsible for bills: \_\_\_\_\_

Billing address: \_\_\_\_\_

Contact number: \_\_\_\_\_

### **Local Doctor**

Medical practitioners name: \_\_\_\_\_

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

Contact number (office): \_\_\_\_\_ (after hrs): \_\_\_\_\_

Fax number: \_\_\_\_\_

Will Dr visit Embleton Care? Yes  No

### **Allergies**

Drug, food or other allergies: \_\_\_\_\_

### **Declaration by applicants:**

I, (the name of the person completing this form) \_\_\_\_\_

do solemnly and sincerely declare that the information contained in this document, and the information contained in any documents submitted as part of this application, is true and correct to the best of my knowledge and belief.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_