

Residential Aged Care Application



Mercy Health

Care first

Thank you for choosing Mercy Health.

Please tick ✓ the Mercy Health home/s that you are applying for:

New South Wales

- | | |
|---|--|
| <input type="checkbox"/> Mercy Place Albury | <input type="checkbox"/> Mercy Place Mount St Joseph's |
| <input type="checkbox"/> Our Lady Mercy Place Harris Park | |

Victoria

- | | |
|---|---|
| <input type="checkbox"/> Mercy Place Abbotsford | <input type="checkbox"/> Mercy Place Montrose |
| <input type="checkbox"/> Mercy Place Ballarat | <input type="checkbox"/> Mercy Place Nixon |
| <input type="checkbox"/> Mercy Health Bethlehem Home for the Aged | <input type="checkbox"/> Mercy Place Northcliffe |
| <input type="checkbox"/> Mercy Health Boronia | <input type="checkbox"/> Mercy Place Parkville |
| <input type="checkbox"/> Mercy Place Colac | <input type="checkbox"/> Mercy Place Rice Village |
| <input type="checkbox"/> Mercy Place Corben | <input type="checkbox"/> Mercy Place Rosebud |
| <input type="checkbox"/> Mercy Place Dandenong | <input type="checkbox"/> Mercy Place Shepparton (Ave Maria) |
| <input type="checkbox"/> Mercy Place East Melbourne | <input type="checkbox"/> Mercy Place Shepparton (South) |
| <input type="checkbox"/> Mercy Place Fernhill | <input type="checkbox"/> Mercy Place Templestowe |
| <input type="checkbox"/> Mercy Place Keon Park | <input type="checkbox"/> Mercy Place Warrnambool |
| <input type="checkbox"/> Mercy Place Lynbrook | <input type="checkbox"/> Mercy Place Wyndham |

Western Australia

- | | |
|---|---|
| <input type="checkbox"/> Edgewater Mercy Hostel | <input type="checkbox"/> Mercy Place Mont Clare |
| <input type="checkbox"/> Mercy Place Lathlain | <input type="checkbox"/> Villa Maria Hostel |
| <input type="checkbox"/> Mercy Place Mandurah | |

Queensland

- Mercy Place Cairns (Bethlehem)

Prior to admission, please return this application with the documents listed on page 2 to one of our staff or email MPEnquiries@mercy.com.au.

Important documents you need to attach to this application:

Please tick ✓ the documents that are relevant to your circumstances and attach them to this application.

- Certified copy of any Power of Attorney, Guardianship/Administration documents
- Residential Aged Care fees letter from Services Australia, if received
- Your most recent invoice and Bond/RAD statement (if applicable), if you are seeking to transfer from another aged care provider

Care needs

- Permanent Dementia specific Respite high Respite low

If respite care: date commencing..... /..... /..... date discharging..... /..... /.....

Admission timeframe

- Urgent Discharge from hospital/TCP Future planning

Proposed discharge date /..... /.....

Are you transferring from another aged care provider? Yes No

Date entered /..... /.....

Applicant details

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other			
Given names			
Family name		Preferred name	
Street address			
Suburb		Postcode	
Phone numbers			
Email address			
Date of birth	/	/	Country of birth
Preferred language for speaking		Preferred language for reading	
Religion		Nationality	
Pension status	<input type="checkbox"/> Full pensioner <input type="checkbox"/> Part pensioner <input type="checkbox"/> Self-funded retiree		

Communication

Who should we contact in relation to this application?

Applicant

Contact person name: _____ (if different to primary contact or authorised representative below):

Relationship to applicant _____

Phone number: _____ Email: _____

Health benefits

Medicare number _____ Expiry: ____/____/____ No. on Card: 1 2 3 4

Centrelink or DVA pension card number _____

If you hold a DVA Health Card, what type is it Gold White Orange

Do you have private health insurance? Yes No

If yes, what is the name of the fund? _____

Membership no: _____

Do you have ambulance membership? Yes No N/A

Membership no: _____

Personal contacts

Primary/emergency contact	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other		
	Given names			
	Family name			
	Relationship			
	Street address			
	Suburb		Postcode	
	Email			
	Phone numbers			
Second contact	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other		
	Given names			
	Family name			
	Relationship			
	Street address			
	Suburb		Postcode	
	Email			
	Phone numbers			

Authorised representative(s) (if any) e.g., enduring power of attorney, medical or financial power of attorney, guardian, administrator, financial manager.	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other		
	Given names			
	Family name			
	Relationship			
	Street address			
	Suburb		Postcode	
	Email			
	Phone numbers			
	Type of legal authority			
Second representative	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other		
	Given names			
	Family name			
	Relationship			
	Street address			
	Suburb		Postcode	
	Email			
	Phone numbers			
	Type of legal authority			
Billing contact	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other		
	Given names			
	Family name			
	Relationship			
	Street address			
	Suburb		Postcode	
	Phone numbers			
	Email			
	Guarantor (if applicable)	Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other	
Given names				
Family name				
Relationship				
Street address				
Suburb			Postcode	
Phone numbers				
Email				

If there are additional contacts, please attach a separate sheet.

General Practitioner

Name: _____

Surgery name: _____

Address: _____

Phone: _____

Email address: _____

Will your GP be visiting you at Mercy Health? Yes No Unknown

National Screening Assessment Form (NSAF) / Aged Care Client Record (ACCR) / Support plan

Do you have an NSAF or ACAR approval for entry to residential aged care? Yes No

ACCR/Support plan date _____ / _____ / _____

Permanent Care Referral Code _____

Respite Care Referral Code _____

If this application is for respite care, please proceed to the Acknowledgement section below. If not, please continue.

Financial section

Important Information

All applicants for permanent care are required to complete a Combined Income and Asset Assessment form (available at <https://www.servicesaustralia.gov.au/sa457>) and submit it to Centrelink or Department of Veterans' Affairs if they wish to receive government assistance with their care and accommodation costs.

The assessment will be used to determine the costs the applicant will be asked to pay and the amount of government assistance they may receive for their aged care costs and accommodation costs. Maximum service fees apply in the absence of this assessment.

Applicants may choose not to disclose their assets and income and pay the maximum service fees.

Have you attached your Services Australia fees advice letter?

Yes No

If yes, please proceed directly to the Acknowledgement and sign.

If no, please continue.

Have you chosen not to disclose your assets and income and to pay the maximum service fees?

Yes No

If yes, please proceed to the Acknowledgement section below and sign.

If no, please continue to the following financial statement.

All applicants are advised to seek independent financial and legal advice to complete the following financial statement.

Information provided in the following financial statement will be used by Mercy Health to estimate the aged care fees and payments that you may be asked to pay.

Mercy Health respects your privacy and the information you provide will not be used for any other purpose except to provide an estimate. Please refer to our *Your Privacy* brochure in your enquiry pack.

Financial statement of assets and income

Do you receive NDIS Funding? Yes No

Do you own or partly own the house, unit or flat in which you normally live? Yes No

If yes, state the market value of the property \$ _____

Share of property value (%) _____

Will your spouse or dependent child continue to live in your home? Yes No

Will your carer, who is eligible for a carer's pension, continue to live in your home? Yes No

Has a close relative, who is eligible for a pension or income support payment, been living in your home for at least five years and continues to do so? Yes No

Do you own or part-own any other residential or commercial property? Yes No

Please list the \$ value of your assets:

Financial (cash, term deposits, bank accounts) \$ _____

Shares and debentures \$ _____

Property and managed trusts \$ _____

Assets gifted in the past three years \$ _____

Other assets \$ _____

Please list the \$ value of your debts: \$ _____

Please list the amount received per fortnight of any pension, superannuation or annuity:

Centrelink/DVA pension \$ _____

Overseas pension \$ _____

Superannuation pension \$ _____

Disability pension \$ _____

Annuity \$ _____

Acknowledgement

1. I warrant that all information provided in this application is accurate to the best of my knowledge and not misleading (including by omission).
2. I acknowledge that Mercy Health relies on me to provide them with accurate information, and I agree to promptly notify them if any information provided in this application is no longer current or is incorrect or misleading.
3. I agree to provide Mercy Health with any materials they reasonably require to verify any of the information provided by me (or on my behalf) in this document.

Signed by the Applicant Applicant's representative Date: ____/____/____

Signature: _____ Print full name: _____

Authority type: _____