Mercy Health
Care first

Residential Aged Care Application

Thank you for choosing Mercy Health.

Mercy Place:

Admission Date ___/___/___

Admission type: ☐ Permanent ☐ Respite

Respite end Date ___/___/___

Mercy Health
Care first

Applicant details

Title ☐ Mr ☐ Miss ☐ Mrs ☐ Ms | Other | Date of birth

First name (s)

Preferred name

Surname

Phone | Email

Current address

Street

Suburb | Postcode

Medicare card number ☐☐☐☐ – ☐☐☐☐☐ – ☐ Reference ☐ Expiry ☐☐ / ☐☐

Is the resident a pensioner? ☐ DVA Pensioner ☐ Centrelink Pensioner ☐ Part pensioner ☐ No (self funded)

Pension/DVA card number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry ☐☐ / ☐☐

Preferred Language: | Religion/ Belief/ Spirituality:

Nationality: | Aboriginal/ Torres Strait Islander:

ACAT (NSAF) approval ☐ Yes ☐ No

Permanent Care Referral Code | Respite Care Referral Code

NDIS ☐ Yes ☐ No

Mercy Health
Care first

General Practitioner

Name:

Surgery name:

Street address:

Suburb Postcode

Phone: Email:

Will your GP be visiting you at Mercy Health?

☐ Yes ☐ No ☐ Unknown

Health benefits

Do you have private health insurance?

☐ Yes ☐ No

Name of the fund:

Membership no:

Ambulance membership no if applicable:

Mercy Health
Care first

Contacts

Primary/ emergency contact

EPOA ☐ Yes ☐ No

Title ☐ Mr ☐ Mrs ☐ Miss Other

Given names Family name

Relationship

Authorised Representative

Street address

Suburb Postcode

Email Phone numbers

Secondary contact

EPOA ☐ Yes ☐ No

Title ☐ Mr ☐ Mrs ☐ Miss Other

Given names Family name

Relationship

Authorised Representative

Street address

Suburb Postcode

Email Phone numbers

Billing contact

EPOA ☐ Yes ☐ No

Title ☐ Mr ☐ Mrs ☐ Miss Other

Given names Family name

Relationship

Authorised Representative

Street address

Suburb Postcode

Email Phone numbers

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
- ☐ Services Australia Fees Advice Letter, if received
- ☐ Your most recent invoice if transferring from another aged care provider

Print Name Date / /