HEYWOOD
Rural Health

Resident Admission Application Form

Surname: _____

Given Names: _____

Room Number: _____

U.R. # _____

Our Vision: *'Committed to the health and wellbeing of our community' ….*

© Heywood Rural Health
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Heywood VIC 3304
Phone: (03) 5527 0555
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Website: www.heywoodruralhealth.vic.gov.au

HEYWOOD Rural Health

Surname: _____

Given Names: _____

Room Number: _____ U.R.#_____

Resident Admission Application Form

Please use black pen to complete this form

Type of Admission:

☐ Respite - Dates of Stay: ____/____/____ to ____/____/____
Or
☐ Permanent - Date of Admission: ____/____/____

Admitted from: ☐ Home ☐ Hospital* ☐ Respite* ☐ other Aged Care Facility*

*Please provide details e.g. Hospital or Facility name: _____

Applicant Details:
If applicable, please write your name as shown on your *Pensioner Concession Card*

Title (Mr. Mrs. Miss. Ms.) _____

Pronouns (He/Him, She/Her, It/Its, They/Them etc.) _____

Surname: _____

Given Name/s: _____

Preferred Name: _____ Maiden Name: _____

Sex at Birth: ☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Intersex ☐ Transgender ☐ Not specified

Date of Birth: ____/____/____

Country of Birth: _____ if Australia, which State: _____

Main Language: _____ Religious Denomination: _____

If you need an interpreter to help you with everyday English, please write the language you speak here: _____

Aboriginal: ☐ No ☐ Yes Torres Strait Islander: ☐ No ☐ Yes

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Home Address: _____

_____

Marital Status: ☐ Single ☐ De facto ☐ Married ☐ Widowed ☐ Divorced
☐ Prefer not to say

Phone Number: Home: _____Mobile _____

Spouse / Partner Information (if applicable):

Are you and your spouse/partner applying together for a place at Heywood Rural Health?
☐ No ☐ Yes

Does your spouse/partner already live in a residential aged care facility?
☐ No ☐ Yes – Name of facility: _____

Do you receive a full or part pension (or other income support payment) from Centrelink or the Department of Veterans' Affairs?

☐ No, I do not receive a pension
☐ Yes, I receive a full pension ☐ Yes, I receive a part pension

What type of pension do you receive?

☐ Centrelink ☐ Aged ☐ Disability ☐ Service Pension

☐ DVA ☐ Gold ☐ White ☐ Orange/Other

☐ Overseas _____

Pensioner/DVA Number:_____Expiry Date:____/____/____

Please write your Medicare details here:
Medicare Number:_____Expiry Date:____/____/____

The number that appears at the left of your name (e.g., 1, 2, etc): _____

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If you have private health insurance, please write your details here:

Name of Health Fund: _____

Health Fund Cover: _____

Health Fund Number: _____ Expiry Date: ____/____/____

If you have ambulance cover, please write your details here:

Ambulance Number: _____ Expiry Date: ____/____/____

Are you required to lodge an annual Income Tax Return with the Australian Tax Office?

☐ No ☐ Yes

Compensation Payments:

Have you claimed and received a compensation award or settlement?

☐ No ☐ Yes

If yes, please indicate the type:

☐ Workers Compensation ☐ Third Party ☐ Common Law

Date of award or settlement ____/____/____

Electoral Roll:

Do you wish for your family member to remain on the Electoral Roll?

☐ No ☐ Yes

If No - forms are available from HRH to ensure this process is managed with ease.

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Nominated Authorised Representative / Emergency Contact:
If you would like Heywood Rural Health to contact a representative on your behalf about this application, or about your care after you enter the aged care facility, please provide details below:

Surname: _____

Given Name: _____

Home Address: _____

_____

Contact numbers: Daytime telephone: _____

Evening telephone: _____

Mobile telephone: _____

Email address: _____

Relationship to you: _____

Enduring Power of Attorney*: ☐ N/A ☐ Medical ☐ Financial ☐ Personal ☐ Guardianship

Second Authorised Emergency Contact:
Heywood Rural Health requires a second contact in case of emergency. Please provide details below:

Surname: _____

Given Name: _____

Home Address: _____

_____

Contact numbers: Daytime telephone: _____

Evening telephone: _____

Mobile telephone: _____

Email address: _____

Relationship to you: _____

Enduring Power of Attorney*: ☐ N/A ☐ Medical ☐ Financial ☐ Personal ☐ Guardianship

Please attach a certified copy of your Enduring Power of Attorney/Medical Treatment Decision Maker or Guardianship papers with this application.

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Responsibility for Paying Accounts & Receiving Correspondence:
Do you wish to be responsible for receiving correspondence from Heywood Rural Health, including accounts?

☐ Yes, I would like to receive my accounts & correspondence

☐ No, I would like my Nominated Authorised Representative to receive my accounts & correspondence

☐ No, I would like the following person/organisation to receive my accounts & correspondence

Surname: _____

Given Name/s: _____

Organisation (if applicable): _____

Address: _____

_____

Contact numbers: Daytime telephone: _____

Evening telephone: _____

Mobile telephone: _____

Email address: _____

Relationship to you: _____

Enduring Power of Attorney*: ☐ N/A ☐ Medical ☐ Financial ☐ Personal ☐ Guardianship

Have you completed an Aged Care Assessment (ACAT)?
☐ No – *To be eligible for admission you must have a current Aged Care Assessment*

☐ Yes

What type of care have you been approved for?

☐ Permanent Residential Care: Approval Date ____/____/____

☐ Respite Residential Care: Approval Date____/____/____

☐ High level ☐ Low level

☐ Home Care Package ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4

Please provide your My Aged Care referral code if known* _____

**Please supply a copy of your current Aged Care Assessment/My Aged Care Support Plan approval letter.

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Existing / Previous Resident of an Aged Care Home:
Do you currently receive, or have you ever received, permanent care in a residential aged care facility?

☐ No ☐ Yes

If yes, please complete the following details:

Name and address of current, or previous, residential aged care facility:

_____

Date you accepted a place: _____/_____/_____ Date of Departure: ____/_____/_____

Did you pay an: ☐ Refundable Accommodation Deposit

$_____ paid on _____/_____/_____

☐ Daily Accommodation Payment

$_____ daily rate

☐ Means Tested Care Fee

$_____ daily rate

General Practitioner

Name: _____

Address: _____

_____

Contact numbers: Daytime telephone:_____

Email address:_____

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Executor

Name: _____

Address: _____

_____

Contact numbers: Telephone: _____ Mobile:_____

Email address: _____

Solicitor:

Name: _____

Address: _____

_____

Contact numbers: Telephone:_____ Fax: _____

Email address: _____

Funeral Directors:

Do you have a funeral Plan? ☐ No ☐ Yes

Please name your Funeral Director of Choice:

Name: _____

Address: _____

_____

Contact numbers: Telephone: _____ Fax: _____

Email address: _____

Advanced Care Directive: ☐ Yes ☐ No

Please provide a copy of your Advanced Care Directive if completed. If unsure please consult with your current General Practitioner.

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Admissions Information

Glasses

Do you wear Glasses? ☐ Yes ☐ No

What colour and shape are they? _____

Who is your Optometrist? _____

When did you last visit? _____

Hearing

Do you wear Hearing Aids ☐ Yes ☐ No Left ☐ Right ☐

What brands are they? _____

What size/type battery do you use? _____

Who is your Audiologist? _____

When was your last visit? _____

Communicating

Do you have any difficulty with your speech? _____

(Finding it difficult to get the right word, stutter etc.)

Do you need time to understand what the other person has said? _____

Do you need the other person to repeat what they have said? _____

Do you usually join in the conversation? _____

Do you generally use single words to join in, or use a sentence? _____

Skin / Wounds

Do you have any skin conditions? Yes ☐ No ☐

If yes, please state what they are and what treatment you are having/taking.

If you are assisted by clinicians such as a Dermatologist, Wound Clinics etc please state.

_____

_____

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Dietary / Nutrition

What foods do you enjoy? _____

_____

What foods do you dislike? _____

_____

Do you have any difficulty swallowing food/s? Yes ☐ No ☐

_____

Do you cough after you swallowed drinks? Yes ☐ No ☐

_____

Do you use any special utensils for eating or drinking eg? Double handled cup? _____

_____

Food and Drinks

What food and drinks do you normally have for the following meals?

Breakfast _____

_____

Morning Tea _____

Lunch _____

_____

Afternoon Tea _____

Dinner _____

_____

Supper _____

You can discuss the menu and food preferences with the care staff on your admission.

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Complementary and Alternate Medications and Treatments

Do you take any Complementary and Alternate Medications? Yes ☐ No ☐
Do you use any Complementary therapy? E.G Acupuncture, Massage, Aromatherapy. Yes ☐ No ☐

If yes please state the medications and if you wish to continue to take these when you are living at HRH. e.g. Vitamins and Minerals, Herbal teas etc. Please also state what complementary therapy you currently use or would like to use.

_____

_____

_____

Emotional / Family & Friends

Are you Married / Partnership Status? _____

Name of Spouse / Significant other _____

Date and place of marriage/s _____

_____

Name of Siblings _____

Names of Children _____

_____

Names of Grandchildren _____

_____

Close Friends / regular visitor's _____

_____

Important People

People who are important to you _____

_____

Others you confide in or want us to help you keep in contact with? _____

_____

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Any other issues regarding relationships with family/friends e.g. requires assistance with keeping in touch with people / would like assistance with face time with children, church etc.

_____

_____

Are there groups you would like to keep in touch with e.g. basketball / football club / probus etc?

_____

_____

Feelings

What stresses you?_____

How do you relax?_____

Do you feel angry at times? Yes ☐ No ☐

What causes you to feel angry? _____

Do you feel Anxious at times? Yes ☐ No ☐

What causes you to feel Anxious? _____

_____

Do you feel depressed at times? Yes ☐ No ☐

What causes you to feel depressed? _____

How do you show your feelings? _____

How do you solve problems? _____

What do you want the staff to know so they can help you when you are not feeling the best?

_____

_____

Hygiene / Mobility / Transfers / Falls / Safety

Do you suffer from any pain? Yes ☐ No ☐

Please describe _____

_____

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Do you suffer from any stiffness? Yes ☐ No ☐

Please describe _____

_____

_____

Hygiene / Mobility / Transfers / Falls / Safety

How often do you shower? _____

What time of the day do you prefer to shower? Morning ☐ Evening ☐

Do you need assistance with?

Washing	Yes ☐	No ☐
Drying	Yes ☐	No ☐
Dressing	Yes ☐	No ☐
Hair	Yes ☐	No ☐
Shaving	Yes ☐	No ☐
Other Grooming	Yes ☐	No ☐

What assistance do you need with getting up off the bed or chair? _____

_____

Do you use a walking frame or other device e.g. walking stick? Describe _____

_____

Have you had any falls in the last year? Yes ☐ No ☐

When? _____

What happened when you fell? _____

_____

Spiritual / Religious / Cultural

What is important in life for you? _____

What spiritual needs do you have? _____

Religion / Belief _____

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Religious / Cultural celebrations you wish to continue _____

_____

Do you wish to attend a church or service? Yes ☐ No ☐

If yes, which church and who will assist you to attend the service _____

_____

Spiritual / Religious / Cultural

What are the significant life experiences you have had? E.g. Love, War, Loss, Successes.

_____

_____

What significant dates e.g. children's birthdays, anniversary, deaths. _____

_____

Life

What level of schooling did you go to? _____

What were your past occupations?_____

_____

What War Service did you do / if any? _____

What Volunteer work did you do / if any? _____

Organization's you were involved in e.g. Senior Citizens _____

Favourites

What are your favourite things to do e.g. listening to the radio / music / sport / painting / writing/ reading etc.?_____

_____

Admission and Evaluation Information

Who are your Health specialists and last appointment date? E.g. Cardiologist, Dermatologist.

a) _____

b) _____

c) _____

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What Allied Health team/s have you been using? Last Appointment Date?

Podiatrist _____ Date _____

Physiotherapist _____ Date _____

Other _____ Date _____

Other Health Questions

Oral and Dental

Do you have your own teeth? Yes ☐ No ☐

Who is your Dentist? _____ Date last seen _____

Do your wear dentures? Upper ☐ Lower ☐

Who is your dental technician _____ Date last seen _____

Medication

Do you take your medications from boxes and bottles?	Yes ☐	No ☐
Do you take your medications from a Webster pack/ other?	Yes ☐	No ☐
Do you know what your medications are and what they are treating you for?	Yes ☐	No ☐
Do you want to self-administer your medications?	Yes ☐	No ☐
Do you want staff to help you with administering your medications?	Yes ☐	No ☐

Is there anything else that is important to you that we should know prior to you coming to live at HRH?

_____

_____

_____

_____

Surname: _____

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Acknowledgement

Please ensure you read this application carefully before signing. If an authorised representative is signing on your behalf, please supply a certified copy of the Enduring Power of Attorney/ Financial and Medical Treatment Decision Maker, and Personal/Guardianship papers.

NOTE: This form is retained by Heywood Rural Health and is not passed on to the Australian Government Department of Health and Aged Care or any other Government agency. If you need your authorised representative to act on your behalf in dealings with Services Australia you will need to complete a separate 'Residential Aged Care: Appointment of a Nominee' form and send it to Services Australia. Forms are available electronically at www.servicesaustralia.gov.au or please ask our Aged Care Services Advisor for a copy.

If you have queries regarding completing this form please do not hesitate to contact our Aged Care Services Advisor on 03 5527 0576.

Signature_____Date__/_____/_____

"At Heywood Rural Health there is surely something nostalgic about the place we call your home".

HEYWOOD Rural Health

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Resident Admission Final Checklist

Please check that you have provided all of the below relevant information:

Item	Check ✔
Medicare Card	
Pension Card	
DVA Card	
Private Health Insurance Card	
Certified copy of Enduring Power of Attorney –Financial/Medical (endorsed)	
Certified copy of Medical Treatment Decision Maker (endorsed)	
Guardianship Administration Board Orders (if application)	
State Trustees details (if applicable)	
Advance Care Plan (if available)	
Fee advice letter for residential fees - 'Assessment of Assets & Income for entry to permanent Residential Aged Care (from either, Centrelink or DVA) or completed and sent to Centrelink/DVA for determination of assets & income.	
Aged Care assessment details or My Aged care Support Plan	
Medication Chart from GP (if applicable)	

Please note: *the documents listed above will be photocopied, with originals returned to you on admission to Heywood Rural Health.*

Please sign in box below to agree to the following statements:

I have received a copy of the Charter of Aged Care Rights Booklet. I have read and understand this information.	**Sign Here**