Kilmore District Health

Application for Respite Care or Permanent Entry

Kilmore District Health Aged Care Facilities

Caladenia Nursing Home & Dianella Hostel

Part A	Applicant Details
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Part C	Accommodation Details
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Introduction

Thank you for considering Kilmore District Health for your residential aged care services.
The information you provide us in this form will help us to get to know you and understand your needs.

We understand that this can be a busy and possibly stressful time for you and your family and we want to assist you through this process where possible. If you need assistance at any time please feel free to contact us.

Before sending please check you have included:

- ☐ ACAT Assessment
- ☐ Application form (this form)
- ☐ Assets & income assessment
- ☐ Copies of any legal authority (eg - power of attorney)

When you've completed as much of the Application Form as you can, please return to:

Kilmore District Health
PO Box 185
Kilmore VIC 3764

What is an ACAT Assessment?
To apply for residential care, an Aged Care Assessment Team (ACAT) needs to have completed an ACAT assessment.
The assessment is free of charge and can be organised by calling My Aged Care on 1800 200 422 (have your Medicare card ready). For more information visit the My Aged Care website at www.myagedcare.gov.au

What is an Assets and Income Assessment?
You will need an Assets and Income Assessment to determine if you are eligible for any assistance from the Australian Government towards your accommodation payment.

To obtain an Assets and Income Assessment, you need to submit a 'Permanent Residential Aged Care Requests for a combined Assets and Income Assessment' form to Centerlink, or the Department of Veterans Affairs (DVA).

You can access the form:

- From your ACAT assessor
- Download at www.humanservices.gov.au
- Contact Kilmore District Health and we can post one to you.

Application for Respite Care or Permanent Entry

Part A

Applicant Details

Please complete the following information. This will help us to get to know you and understand your needs.

Please provide your My Aged Care referral codes below.
Residential Permanent:_____
Residential Respite Care:_____

Title_____ First name_____Last name_____

Preferred name _____Gender pronoun_____

Address _____

Suburb/Town _____State_____Postcode __ __ __ __

Home phone _____ Mobile _____

Email _____

Date of Birth ____ /____ / ___

Marital status (please circle) Married Single Widowed De Facto

Country of birth_____

Cultural background _____

Religion (optional) _____

Are you Aboriginal or Torres Strait Islander? (please circle)

Aboriginal	Yes	No
Torres Strait Islander	Yes	No
Neither	Yes	No

Do you require an interpreter for everyday English? **(please circle)** Yes No

Person completing this form

Is the applicant the primary contact for this application? **(please circle)** Yes No

If no, please complete Part B on the following page.

I certify that to the best of my knowledge all information in this application is correct

Signed _____Date: ____ /____ /_____

Full Name _____

Part B

Contact & Legal Details

Primary Contact Details

Please provide details for the person(s) we can contact regarding your application and for the duration of your time with us.

Primary Contact

Title _____ First Name(s) _____

Last Name _____

Relationship to the applicant (eg. son/daughter)_____

Tick the options that apply

☐ Billing Contact ☐ Clinical Contact ☐ Legal Contact

☐ Other _____

Address Street _____

Suburb _____ State _____ Postcode __ __ __ __

Home phone _____ Mobile _____

Email _____

Secondary Contact

Title _____ First Name(s) _____

Last Name _____

Relationship to the applicant (eg. son/daughter)_____

Tick the options that apply

☐ Billing Contact ☐ Clinical Contact ☐ Legal Contact

☐ Other _____

Address Street _____

Suburb _____ State _____ Postcode __ __ __ __

Home phone _____ Mobile _____

Email _____

Part B

Contact & Legal Details (continued)

Legal Details

Please note, if you answer yes to any of the following questions, you need to supply a copy of the relevant documentation.

Do you have a Power of Attorney? **(please circle)** Yes No

If yes, Full name of Attorney _____

Type of Attorney

- ☐ Enduring Power of Attorney (Medical)
- ☐ Enduring Power of Attorney (Financial)
- ☐ Enduring Power of Guardianship
- ☐ General Power of Attorney

Do you have a Legal Guardian? **(please circle)** Yes No

If yes, Type of Guardian

- ☐ Public Trustee
- ☐ Office of protective commissioner
- ☐ Guardianship Tribunal
- ☐ Other _____

Part C

Accommodation Details

Which type of accommodation do you require?

☐ Permanent only ☐ Permanent & Respite ☐ Respite Only

In which facility?

☐ Caladenia ☐ Dianella ☐ Either

Where do you live at the moment?

- ☐ A residential care facility - Facility Name _____
- ☐ In hospital awaiting placement
- ☐ In transitional care
- ☐ With a family member
- ☐ My own home
- ☐ Other **(please provide details)** _____

_____

When do you require accommodation?

- ☐ As soon as possible
- ☐ Future date **(please advise)** _____

Please complete the following for respite only:

Have you accessed respite in this financial year? **(please circle)** Yes No

If yes, how many days? _____

Income & Asset Details

Please note: This section is not required for Respite Only applications

This information will be used to estimate your fees. Asset details are not required to be completed if an Assets and Income Statement is provided with this application

Income Details

Pension Details

Do you receive a pension?

☐ Full pension ☐ Part pension ☐ No I don't receive a pension

If yes, what type of pension do you receive?

☐ Age ☐ Disability ☐ Widow

☐ DVA ☐ Blind ☐ Overseas

Pension concession card number **(if applicable)** _____

Expiry Date _____

DVA treatment card number **(if applicable)** _____

Expiry Date _____ Colour: **(please circle)** Gold White Orange

Other Income

Current income you receive	Fortnight	Month	Year
	Complete one column only		
Centerlink or DVA pension			
Superannuation			
Overseas Pension			
Rental property income			
Business income			
Trust distributions and/or share dividends			
Other (please specify source)			

Income & Asset Details (continued)

Part D

Asset Details

Do you and/or your partner own, or are currently paying off the home you live in?

(please circle) Yes No

Your home will be included as an asset unless it is occupied by a protected person. A protected person is:

your partner or dependent child

- your carer who has lived with you in the home for the past two years and is eligible for an income support payment
- a close relation, such as a sister, brother, parent, child or grandchild who has lived with you in the home for the past five years and is eligible for an income support payment

Will a protected person live in the family home? **(please circle)** Yes No

What is the estimated current value of your home? _____

What is the current value of your financial assets **(list below)**

If you have a current partner please record your share only. (ie - $50,000 shares for husband and wife = $25,000 asset for individual)

Financial Asset	Current Value
Cash and Bank accounts	
Managed Investments	
Listed Shares and securities	
Loans	
Unlisted shares	
Gold and bullion	
Gifted assets (above $10,000 in last 12 months or $30,000 in last 5 years	
Other (please specify source)	

Part D

Income & Asset Details (continued)

What is the current value of your other assets?

Other Asset	Current Value
Household Contents (typically valued at $10,000)	
Foreign assets inc business interests, real estate and investments	
Investment property	
Special collections such as art works, antiques or stamps	
Superannuation balances	
Private trusts, family trusts and private companies	
Refundable accommodation deposits	
Car, Boat, Caravan, Other (please specify source)	

What is the current value of your debts?

Debt	Current Value
Credit card	Not Applicable
Personal Loans (only include personal loans if it is held over an asset listed above)	
Mortgage taken out for the benefit of someone else	Not Applicable
All other loans, encumbrances, charges, debts, mortgages	

Part E

Health Cover Details

Medicare Details

Medicare Number _____

Individual Reference Number _____ Valid to ___ / _____

Health Fund Details

Health Insurance Provider _____

Membership Number _____

Type of Cover _____

Ambulance Cover

Membership Number (if applicable) _____

Expiry Date ___ / ___ / ____

Medical Details

Medical Contacts

Your General Practitioner (GP)

Name of GP _____

Name of GP Medical Practice _____

Address Street _____

Suburb _____ State _____ Postcode __ __ __ __

Phone _____ Fax _____

Email _____

Other Health Professionals important to your care

Name _____

Field/Speciality _____

Phone _____ Fax _____

Email _____

Name _____

Field/Speciality _____

Phone _____ Fax _____

Email _____

Name _____

Field/Speciality _____

Phone _____ Fax _____

Email _____

Medical Details (continued)

Medical Information

While your ACAT assessment will advise us of your medical details, we need to know of any particular medical or health conditions that may affect your care on a daily basis. All information will be kept private, as required by state and commonwealth legislation.

Please list any known medical conditions, events and previous surgeries you have / had (eg, diabetes, arthritis, high blood pressure, depression, joint replacement, etc)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any medications you take and the dosage

_____

_____

_____

_____

_____

_____

_____

_____

_____

Part F

Part F

Medical Details (continued)

Please list any allergies (eg, food, drugs, etc)

_____

_____

_____

_____

_____

_____

Is there anything else we should know about your health that is not covered in your ACAT Assessment?

_____

_____

_____

_____

_____

Do you have an advanced health directive? **(please circle)** Yes No
If yes, please bring a copy with you on admission

Any other information you would like us to have?

_____

_____

_____

_____

_____

Submission of Documentation

Once completed please return this form to:
Kilmore District Health
Aged Care Admission
PO Box 185
KILMORE VIC 3764

Please ensure you have attached the following:

- ☐ ACAT assessment letter
- ☐ Income & Assets statement
- ☐ Copies of legal documents

If you have any questions in relation to this form please contact one of our friendly staff for assistance:

Caladenia Manager	03 5734 2155
Dianella Manager	03 5734 2030
Finance Department	03 5734 2165 KDHaccfinance@kilmorehealth.org.au

Application for Respite Care or Permanent Entry

What happens next?

- Kilmore District Health will review your application and add you to the waiting list
- When a bed becomes available we will contact you
- If your health or financial circumstances changes, please let us know
- If you no longer wish to be on the waiting list, please let us know.

Kilmore District Health

Address: 1 Anderson Road, Kilmore, Vic, 3764
Postal: PO Box 185, Kilmore, Vic, 3764
Phone: (03) 5734 2000
Email: kilmoreweb@kilmorehealth.org.au

Caladenia Nursing Home

Address: 1 Anderson Road, Kilmore, Vic, 3764
Phone: (03) 5734 2155
Email: kilmoreweb@kilmorehealth.org.au

Dianella Hostel

Address: 1 Anderson Road, Kilmore, Vic. 3764
Phone: (03) 5734 2170
Email: kilmoreweb@kilmorehealth.org.au

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