Permanent Resident Application Form

Please return the completed form to:

The Client Liaison Officer
KALYNA CARE
344 Taylors Road, Delahey 3037
Telephone: 03 9116 4100 Fax: 03 9116 4101

Email: info@kalynacare.com.au or

michelle.goltz@kalynacare.com.au

OFFICE USE ONLY	
Resident Name	
Admission Date	
Date Application Received	
Labels Ordered	
Room Confirmation & Payment Method	
Room Selection **Room Number** _____	☐ Konvalyia Renovated Room ☐ Konvalyia Premium Room ☐ Topolya Standard Room ☐ Sosna Standard Room ☐ MH Standard Room ☐ MH Renovated Room
Payment Method ***Note: The DAP will be charged from admission until the RAD amount is paid***	☐ Fully Supported Resident ☐ Partially Supported Resident ☐ DAP Only (Daily Accommodation Payment) ☐ RAD Only (Refundable Accommodation Payment) ☐ Combination Payment RAD/DAP RAD amount to be paid: $_____

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Resident Details			
Title	Mr Mrs Ms Miss Dr Other_____		
Surname / Last Name			
First/Given Name(s)			
Preferred Name			
Address			
Phone Number			
Date of Birth			
Country of birth **Year arrived in Australia**		**Religion**	
Languages Spoken			
Do you speak English?	**YES** **NO** *(Please circle one)* **Do you require an interpreter?** **YES** **NO** *(Circle one)*		
Marital Status **Partner's Name**	*(Please circle)* Single / Married / Separated / Divorced / Widow / Widower		
ACAT/My Aged Care APPROVAL CODE	**1-**		
Aged Care Number	**AC-**		
Medicare Card No.	**Reference/Line No:** **Expiry Date:**		
Pension Card No.	**Expiry Date:**		
Pension Level	Full Pensioner / Part Pensioner / Non Pensioner *(Circle one)*		
Pension Type	Aged Pension / Disability Pension / Other _____		
DVA Card No. (If applicable)	**DVA Card Colour:** **Expiry Date:**		
Do you have Private Health Insurance?	**Fund Name:** **Level/Cover:** **Member Number:**		
Do you have Ambulance Cover?	**YES** **NO** *(Please circle one)* **Member Number:**		
Do you have PBS registration?	**YES** **NO** *PBS = Pharmaceutical Benefits Scheme* **Registration Number:**		

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Are you an NDIS participant?	**YES NO** *(Please circle one)* **Registration No:**		
NDIS Support Officer Name:		**Phone**	
Primary Disability *(For NDIS participant only)*			
NDIS Fund Management:	**Self-Managed Plan Managed NDIA Managed** *(Please circle one)*		
Hospital of Choice *(if medically appropriate)*			
Are you on the Electoral Role? *(Circle one)*	**YES** **NO** **I no longer wish to vote**	**(Note: The resident/family is responsible for changing the address or removing the person from the role)**	

Authorised Person Details (First Contact)

(Only a legally authorised person may admit a resident to Residential Care)

First Name		
Surname		
Relationship to Resident		
Authority Status *(Documentation required)*	☐ Enduring Guardianship ☐ Medical Power of Attorney ☐ Administrator	☐ General (Non-enduring) Power of Attorney ☐ Financial and/or Personal Power of Attorney ☐ Other/None_____
Address		
Phone Numbers *Please tick preferred number*	**Home:** ☐ **Mobile:** ☐ **Work:** ☐	
Email Address		
Drivers Licence No	**State Issued:**	

Secondary Person Contact Details

(In case of emergency or if authorised person is not available)

First Name		
Surname		
Relationship to Resident		
Authority Status	☐ Enduring Guardianship ☐ Medical Power of Attorney ☐ Administrator	☐ General (Non-enduring) Power of Attorney ☐ Financial and/or Personal Power of Attorney ☐ Other/None_____
Address		
Phone Numbers *Please tick preferred number*	**Home:** ☐ **Mobile:** ☐ **Work:** ☐	
Email Address		
Drivers Licence No	**State Issued:**	

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Additional Person Contact Details *(In case of emergency or if authorised person is not available)*	
First Name	
Surname	
Relationship to Resident	
Authority Status	☐ Enduring Guardianship ☐ General (Non-enduring) Power of Attorney ☐ Medical Power of Attorney ☐ Financial and/or Personal Power of Attorney ☐ Administrator ☐ Other/None_____
Address	
Phone Numbers *Please tick preferred number*	**Home:** ☐ **Mobile:** ☐ **Work:** ☐
Email Address	
Drivers Licence No	**State Issued:**

Financial Manager Details *(Who will be responsible for payment of invoices?)*	
First Name	
Surname	
Address	
Relationship to Resident	
Authority Status	☐ Enduring Guardianship ☐ General (Non-enduring) Power of Attorney ☐ Medical Power of Attorney ☐ Financial and/or Personal Power of Attorney ☐ Administrator ☐ Other/None_____
Phone Numbers *Please tick preferred contact number*	**Home:** ☐ **Mobile:** ☐ **Work:** ☐
Email Address	
I would like invoices sent by	☐ Post ☐ Email

State Trustee Details *(if applicable)*	
State Trustee (resident) Client Number	
Client Manager Name	
Client Manager Phone	
Client Manager Email	

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NDIS Nominee Details *(if applicant is unable to sign on their own behalf, who does NDIS contact?)*	
First Name	
Surname	
Address	
Phone Numbers *Please tick preferred contact number*	**Home:** ☐ **Mobile:** ☐ **Work:** ☐
Email Address	
Contact Instructions	

Previous Aged Care Experience *(Please complete if transferring from another facility)*	
Have you ever been or are currently in another Residential Aged Care Facility? ☐ **YES** ☐ **NO**	
Admission/ Commencement Date	
Have you paid an Accommodation Bond, Refundable Accommodation Deposit or Payment Contribution to another facility? ☐ **YES - Paid as:** ☐ **Lump Sum $**_____ ☐ **Daily Fee $**_____ ☐ **NO**	
Was the lump sum paid back in full?	☐ **YES** ☐ **NO - Reason** _____
Facility Name	
Address	
Contact Person Name	
Phone Number	
Email	

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Means Test Estimator

Please complete the details below to assist in forecasting fees and charges

Please note that is an estimation only.
It is recommended that you complete the Income and Asset Assessment with Services Australia (Centrelink).

I own or part own the house, unit or flat in which I normally live ☐ **YES** ☐ **NO**	
I have a spouse/partner/carer or dependent child living with me who receives a Carer's Payment ☐ **YES** ☐ **NO**	**The person living with me will be remaining in the house after I leave** ☐ **YES** ☐ **NO**

Assessable Assets			
Home (Net Market Value)	$	Private Trusts and Companies	$
Net Retirement Village Contribution *(if applicable)*	$	Gifts / Deprivation *(monies you have gifted to someone else)*	$
Previous Accommodation Bond / RAD paid *(if applicable)*	$	Other Assets	**$**
Financial /Bank Account Totals (Savings/Cheque, Term Deposits)	$	**Asset Reduction**	
Shares	$	Personal Loans	$
Managed Investments	$	Other Debts	$
Assessable Income Streams	$	POW Compensation	$
Foreign Assets	$	Private Trusts and Companies	$
Real Estate and Business Assets	$		

Assessable Income		**Income Frequency**
Centrelink/DVA Pension	$	☐ Fortnightly ☐ Annually
Disability Pension	$	
Overseas Pension	$	
Other Income	$	
I have submitted an Income and Asset Assessment with Services Australia (Centrelink)		☐ YES ☐ NO **Submission Date:**

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Document Checklist

Please ensure that you have completed and provided the documents below for admission:

- ☐ Permanent Application Form
- ☐ Copy of Legal Authority Document (Power of Attorney, Guardianship, etc)
- ☐ Copy of Services Australia (Centrelink) Income and Asset Assessment Letter (if completed)
- ☐ Copy of Previous Aged Care Facility Payment proof or Agreement (if applicable)
- ☐ Consent to Medical Care Form
- ☐ Pre-admission Lifestyle Information Form
- ☐ Lifestyle Consent Form
- ☐ Privacy Consent Form
- ☐ Telehealth Consent Form
- ☐ Allied Health and other Specialists Contact List
- ☐ Rules and Guidelines for Electrical Equipment
- ☐ Nominated Funeral Director and Advanced Care Plan Form
- ☐ Advance Care Directive for Adults (for someone signing on your behalf), ***OR***
- ☐ Advance Care Directive for Adults
- ☐ Permanent Medication Chart – *To be completed by the resident's GP 1 week prior to admission*
- ☐ Medical Summary – *To be completed by the person's GP 1 week prior to admission*
- ☐ Resident Vaccination Information - *To be completed by the person's GP 1 week prior to admission*
- ☐ EziDebit Direct Debit Authorisation Form
- ☐ Acher Pharmacy Admission Form