APPLICATION FOR ANGUS MARTIN HOUSE SUPPORTED RESIDENTIAL SERVICE

AUTHORISATION FOR CENTRELINK

(INCOME AND ASSET CONSENT)

Provided by Australian Government Department of Human Services

This consent will be used for the sole purpose of authorising Australian Government Department of Human Services ("Department of Human Services") to provide information to Wintringham / Wintringham Housing to assess your eligibility in relation to concessions or services provided by Wintringham / Wintringham Housing.

I _____, CRN _____& D.O.B____/____/_____ authorise Department of Human Services to electronically provide a statement of information to Wintringham / Wintringham Housing to assist in the assessment of my entitlement to services from Wintringham / Wintringham Housing. I understand that the information provided by Department of Human Services may include, where relevant, current or historical details of payments received, dependants, Centrelink deductions, income, assets and *confirmation* of my current address.

I understand that this authority, once signed, is effective only for the period I am a customer of Wintringham / Wintringham Housing. I understand that this authority, which is ongoing, can be revoked at any time by giving notice to Wintringham / Wintringham Housing

I understand that I will be able to obtain a written copy of the Statements at any time from either Wintringham / Wintringham Housing or Department of Human Services.

I understand that if I withdraw part or all of this consent that I may not be eligible for the concessions provided by Wintringham / Wintringham Housing and that I will be responsible for notifying Australian Government Department of Human Services of all future changes to my accommodation circumstances. For more information about the Centrelink Confirmation eServices go to www.humanservices.gov.au

Signature: _____ Date: _____/_____/_____

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1. APPLICANTS DETAILS:

NAME: SURNAME _____

GIVEN NAMES _____

DATE OF BIRTH: _____

ADDRESS: _____

POSTCODE: _____

TELEPHONE: _____

GENDER: ☐ Male ☐ Female

MARITAL STATUS: ☐ Married ☐ DeFacto

☐ Never Married ☐ Widowed

☐ Divorced ☐ Separated

ABORIGINAL / TORRES STRAIT ISLANDER ☐ Yes ☐ No

VETERAN ☐ Yes

INTERPRETER REQUIRED ☐ Yes

Please state language _____

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2. REFERRAL SERVICE:

☐ SELF Go to Part 3 ☐ OTHER Please continue

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____ FAX: _____

3. NEXT OF KIN / GUARDIAN / PERSON NOMINATED:

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____

RELATIONSHIP:

☐ Relative ☐ Friend
☐ Case worker ☐ Guardian
☐ Other _____ Please Specify

DOES THE GUARDAIN / NEXT OF KIN / PERSON NOMINATED WISH TO BE CONTACTED FOR CHANGES IN RESIDENTS CONDITION:

YES ☐ NO ☐

IF YES PLEASE WRITE YOUR PREFERRRED CONTACT DETAILS:

PHONE:_____

EMAIL: _____

4. FINANCIAL INFORMATION:

☐ Centrelink: Aged ☐ DVA: Service pension

☐ Centrelink: Disability ☐ DVA: Service plus Disability

☐ Centrelink: Other ☐ Superannuation

☐ Overseas Pension ☐ Other _____ Please specify

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PENSION NUMBER: _____

FINANICAL MANAGEMENT:

- ☐ Self
- ☐ Power of Attorney
- ☐ Administrator

DETAILS OF POWER OF ATTORNEY / ADMINISTRATOR:

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____

5. BILL TO:

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____

6. CURRENT HOUSING:

- ☐ Own Home
- ☐ Private Rental
- ☐ Public Housing
- ☐ Rooming House
- ☐ Private Hotel
- ☐ Emergency Accommodation
- ☐ Street / Car
- ☐ Independent Living Unit
- ☐ Family
- ☐ Aged Care Facility
- ☐ Other Please Specify .....

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7. HEALTH INFORMATION:

DOCTOR: _____

ADDRESS: _____

POSTCODE:

TELEPHONE: _____

MEDICARE NO: _____

PRIVATE HEALTH INSURANCE ☐ Yes ☐ No

8. SERVICES:

Please tick the boxes for the services that are currently received by the applicant and any services that are considered to be required:

	RECEIVED	REQUIRED
• Home Help eg. assistance with cleaning & laundry	☐	☐
• Meal Services eg. Meals on Wheels	☐	☐
• Personal Care eg. Help with hygiene, medication etc.	☐	☐
• Royal District Nursing Services	☐	☐
• Shopping	☐	☐
• Transport	☐	☐
• Assistance with Financial matters	☐	☐
• Social support and activities	☐	☐
• Other (please specify): _____	☐	☐
_____	☐	☐

Are you a current recipient of the National Disability Insurance Scheme (NDIS)?

☐ Yes ☐ No

If yes, what is your Participant Number? _____

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9. GENERAL

(please tick the appropriate columns)

DO you need any help with the following:	Please tick to indicate how much help do you need			
	No help	Help to set up	Supervision	Assistance
Eating				
Transferring				
Walking				
Dressing/Undressing				
Washing and Drying				
Grooming (Shaving, Hair, Teeth)				
Using Toilet				
Toilet Hygiene (hand washing, dressing)				

Do you	Yes	No	Unsure	Comments
Ever have any incontinence?				
Forget things?				
Follow instructions easily?				
Ever wander and get lost?				
Ever get angry?				
Ever get frustrated?				
Suffer from depression?				
Take any regular medication?				
Take medication more than once per day?				
Drink alcohol every day?				
Have any problems taking medication?				
Need injections for anything (e.g. Insulin)?				
Use an allied health provider (e.g. podiatrist, physiotherapist, RDNS)?				
Need blood pressure monitoring (more than weekly)				
Need blood sugar levels taken				
Need pain medication				
Need pressure area care				
Need special feeding (what type)				
Need catheter care				
Need wound care				
Wear compression stockings				
Need oxygen therapy				
Have a stoma				
Need tracheostomy care				

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10. OTHER INFORMATION

Is there any other information you would like to add?

11. SIGNATURE

APPLICANT or
REPRESENTATIVE: _____

DATE: _____

Please note

- All information provided to Wintringham will remain confidential and is needed to assess the applicants suitability for Residential Aged Care
- The purpose of the Application Form is to identify prospective residents. It does not constitute any agreement by Wintringham to provide services.
- Completed application forms are to be sent to:

Wintringham – Advice and Information
136 Mt Alexander Rd
Flemington 3031

OR

PO Box 193
Flemington VIC 3031

Phone: (03) 9034 4824 **Fax: (03) 9376 8138**

Admin use only Date Application Received: