SRS – APPLICATION FORM

Before completing this application, please refer to ***I Need a Home > Information Pack > Supported Residential Service*** on the Wintringham website: www.wintringham.org.au or please contact Intake and Service Information on (03) 9034 4824.

1. Client Details

First Name:		Surname:	
DOB:			
Preferred Name:		Pronouns:	
Address(current/postal):			
Phone:		Mobile:	

2. Client Information

Gender identity:		Preferred language:	
LGBTIQA+:		Interpreter required:	
Indigenous status		If Yes, language:	
Veteran:		Cultural background:	
Forgotten Australian:		Religion / belief:	
Country of birth:		Citizenship:	
Relationship Status:			

3. Client ID

Income type:		Medicare number:	
Centrelink number:		Medicare expiry date:	
Aged Care number:		NDIS Number:	
HCP Provider Name:		Plan Date – Start:	
		Plan Date – End:	
Financial Management (*e.g. self, POA, administrator*):		NDIS Provider Name:	

4. Referral Source *(Self-referral go to next question)*

Organisation		Relationship:	
Worker's Name:		Phone:	
Email:			

5. Are you currently a Wintringham Client?

☐ Yes ☐ No

If so, which site/program: _____

6. Housing

Experiencing homelessness? *If yes, how long have you been homeless?*	
Service Evictions/Refusal?	
Current housing situation:	
Name of facility/organisation?	

Options Dignity Rights

Wintringham HOUSING

7. Important Information

Describe your cultural and family circumstances:	
Anything you love to do or hate doing?	
Any behaviours we should be aware of? *e.g., Aggression – to or from others* *History of violence* *Alcohol and Other Drug issues*	
Forensic History?	
Any triggers we should be aware of? *(i.e. environment, people, past experience)*	
Any disability considerations? *e.g. communication needs (i.e., literacy - reading, writing), mobility (walking stick/ Frame/ Wheelchair/ scooter)*	
Mental Health and Cognitive Impairments *diagnosed or suspected- Mental Illness, addiction, dementia, ID, ABI, ARBI*	
Do you own a Pet?	☐ Yes ☐ No Describe:
Have you previously experienced violence in the home or in your relationships?	☐ Yes ☐ No
Do you need any immediate assistance to feel safe?	☐ Yes ☐ No
If YES, you can call for Victoria Safe Steps on 1800 015 188 or police if necessary.	

8. Health Information

Ask your GP to complete Medical History Form and attach to application.

Doctor Name: _____

Clinic Name: _____ Phone: _____

Private Health Insurance? ☐ Yes ☐ No

COVID Vaccination? ☐ Yes ☐ No

Flu Vaccination? ☐ Yes ☐ No

Wintringham HOUSING

9.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 *e.g. assistance with cleaning & laundry*	☐	☐
Delivered meals	☐	☐
Personal Care *e.g. help with hygiene, medication etc*	☐	☐
Royal district nursing services	☐	☐
Shopping	☐	☐
Transport	☐	☐
Assistance with financial matters	☐	☐
Social Support and activities	☐	☐
Other (please specify):	☐	☐

10. General Activities of Daily Living

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, Boltan Clarke)?	☐	☐	☐	
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	☐	☐	☐	

11. Emergency Contact/Next of Kin/ Person Nominated

First Name: _____ Surname: _____

Phone: _____ Mobile: _____

Email: _____

Relationship to client: _____

Does the Next of Kin/Guardian/Person Nominated wish to be contacted for changes in residents' condition on the above contact details? ☐ Yes ☐ No

12. Guardianship

☐ Yes ☐ No – proceed to next question

☐ Medical ☐ Accommodation ☐ Other- *please specify* _____

Name: _____ Organisation: _____

Phone: _____ Mobile: _____

Email: _____

Relationship to client: _____

13. Power of Attorney

☐ Yes ☐ No – proceed to next question

First Name: _____ Surname: _____

Phone: _____ Mobile: _____

Email: _____

Relationship to client: _____

14. Administrator

☐ Yes ☐ No – proceed to next question

Name: _____ Organisation: _____

Phone: _____ Mobile: _____

Email: _____

Relationship to client: _____

15. Person Responsible for Paying Fees

☐ Yes ☐ No – proceed to next question

Name: _____ Organisation: _____

Phone: _____ Mobile: _____

Email: _____

Relationship to client:

16. Centrelink Authority

Provided by Australian Government Agency Services Australia

For more information about the Centrelink Confirmation eServices go to www.servicesaustralia.gov.au.

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

I authorise the Agency to electronically provide a statement of information to Wintringham to assist in the assessment of my entitlement to services from Wintringham. I understand that the information provided by the Agency 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. I understand that this authority, which is ongoing, can be revoked at any time by giving notice to Wintringham.

I understand that I will be able to obtain a written copy of the Statements at any time from either Wintringham or the Agency.

I understand that if I withdraw part or all of this consent that I may not be eligible for the concessions provided by Wintringham and that I will be responsible for notifying the Agency of all future changes to my accommodation circumstances.

Full Name:_____ DOB:_____

Signature: _____ CRN: _____

17. Pharmacy Admission

Pharmaceutical Benefit Entitlement details: please tick

☐ None ☐ Safety Net ☐ Pension

☐ DVA ☐ Fully Supported ☐ Partially Supported

☐ Non-Supported

Generic Substitution Ok? ☐ Yes ☐ No

Account/s forward to:

Name: _____

Address: _____ Postcode: _____

Provision of information for this document indicates acceptance of services from, and permission for Wintringham to provide confidential information to Pharmacy.

☐ I consent to the collection of my personal information by the Department of Health and Pharmacy Programs Administrator to confirm my eligibility to receive the Residential Medication Management Review Service that Wintringham's preferred accredited consultant pharmacist may provide to me.

My personal information includes:

- Medicare Number and date of birth,
- The medication you are taking and
- Other health information

This consent applies to any/all RMMRs performed or deemed necessary, while I am residing at Wintringham.

Client/Advocate Signature: _____ Date: _____

18. Any Other Additional Support Needs?

19. Client Consent

Written applicant consent (Please tick if this option is selected)	☐
This referral has discussed with me, and I give consent for my information to be shared with Wintringham, for the purposes of the referral. I agree and consent to Wintringham contacting other external agencies in order to confirm my personal and/or health status for the purposes of my application, and that any information collected during this process will be disposed of, in accordance with the Privacy and Data Protection Act 2014, should my application be unsuccessful.	
Applicant Name:	
Signature:	
Date of signature	
If the application has been completed on behalf of the applicant, please provide details below	
Name:	
Relationship to applicant:	
Contact number:	
I have supported the applicant to complete the application and am responsible for providing true and accurate information on behalf of the applicant.	
Signature of support person:	

Or

Verbal applicant consent (agency use only) (Please tick if this option is selected)	☐
I have discussed and informed the applicant about the information in this document being shared with Wintringham, as part of the referral process. I am satisfied that this has been understood by the applicant and that informed consent has been provided for the information to be shared.	

Before you submit your application, have you attached the following?	Tick ✓
Pet Assessment & Agreement (if applicable)	☐
Copy of your Medical History Form completed by your GP	☐

PLEASE NOTE

All information provided to Wintringham will remain confidential and is needed to assess the applicant's suitability for Supported Residential Service.

The purpose of the Application Form is to identify prospective residents. It does not constitute any agreement by Wintringham to provide services.

Please save and submit your application via:

Email:
intake@wintringham.org.au

Or

Post:
Intake and Service Information
PO BOX 193
Flemington VIC 3031

ADMIN USE ONLY
Date application received:

Options Dignity Rights