

# 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](http://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? <i>If yes, how long have you been homeless?</i>	
Service Evictions/Refusal?	
Current housing situation:	
Name of facility/organisation?	

## 7. Important Information

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

## 8. Health Information

 Ask your GP to complete Medical History Form and attach to application.	
Doctor Name:	_____
Clinic Name:	_____ Phone: _____
Private Health Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
COVID Vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flu Vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 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	<input type="checkbox"/>	<input type="checkbox"/>
Delivered meals	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care e.g. help with hygiene, medication etc	<input type="checkbox"/>	<input type="checkbox"/>
Royal district nursing services	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Transport	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with financial matters	<input type="checkbox"/>	<input type="checkbox"/>
Social Support and activities	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>

## 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?			
			<input type="checkbox"/> Yes <input type="checkbox"/> No

## 12. Guardianship

<input type="checkbox"/> Yes <input type="checkbox"/> No – proceed to next question			
<input type="checkbox"/> Medical	<input type="checkbox"/> Accommodation	<input type="checkbox"/> Other- <i>please specify</i>	_____
Name:	_____	Organisation:	_____
Phone:	_____	Mobile:	_____
Email:	_____		
Relationship to client:	_____		

## 13. Power of Attorney

<input type="checkbox"/> Yes <input type="checkbox"/> No – proceed to next question			
First Name:	_____	Surname:	_____
Phone:	_____	Mobile:	_____
Email:	_____		
Relationship to client:	_____		

## 14. Administrator

<input type="checkbox"/> Yes <input type="checkbox"/> No – proceed to next question			
Name:	_____	Organisation:	_____
Phone:	_____	Mobile:	_____
Email:	_____		
Relationship to client:	_____		

## 15. Person Responsible for Paying Fees

<input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None          | <input type="checkbox"/> Safety Net      | <input type="checkbox"/> Pension             |
| <input type="checkbox"/> DVA           | <input type="checkbox"/> Fully Supported | <input type="checkbox"/> Partially Supported |
| <input type="checkbox"/> 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

<b>Written applicant consent</b> (Please tick if this option is selected)		<input type="checkbox"/>
<i>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.</i>		
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>I have supported the applicant to complete the application and am responsible for providing true and accurate information on behalf of the applicant.</i>		
Signature of support person:		

**Or**

<b>Verbal applicant consent (agency use only)</b> (Please tick if this option is selected)		<input type="checkbox"/>
<i>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.</i>		

<b>Before you submit your application, have you attached the following?</b>	Tick <input checked="" type="checkbox"/>
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.

You can submit your application via:

**Email:**  
[intake@wintringham.org.au](mailto:intake@wintringham.org.au)

Or

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

<b>ADMIN USE ONLY</b> Date application received:
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