

PLEASE COMPLETE ALL QUESTIONS IN THIS FORM

If the answer is unknown either write "Unknown" or "Not Applicable" in the space provided

Personal details

Title: Mr Mrs Ms Other (*please specify*): _____

Surname: _____ Given Name(s): _____

Applicant's Hebrew Name: _____

Mother's Hebrew Name: _____

Father's Hebrew Name: _____

Date of Birth: _____ Gender: _____

Country of Birth: _____ Town of Birth: _____

Main Languages Spoken: _____ Other Languages Spoken: _____

If born overseas, date arrived in Australia: _____ Are you an Australian citizen? Yes No

Are you a Holocaust Survivor? Yes No

Are you a Child Survivor? (born between 1928 & 1944) Yes No

Marital Status: Single De facto Married Separated Divorced Widowed Unknown

Religion: _____ Former occupation: _____

Are you a current member of Montefiore? Yes No

How many years have you been a member? _____ years

If not, would you like to apply for membership? Yes No

Do you hold Synagogue membership? Yes No

If yes, which congregation? _____

Residential address: _____

Telephone number: Home: _____ Mobile: _____

Income Status:

Self-Funded Full aged pension Workers' Compensation Part aged pension Third Party

DVA (*type*): _____ Other: (*specify*): _____

Have you had a respite stay in any Aged Care Facility at all in the past 12 months: Yes No

Pension Number: _____ Expiry Date: _____

Medicare Number: _____ Expiry Date: _____ Patient No. on Card: _____

Pharmaceutical Benefits Number: _____ PBS Safety Net number: _____

Health Fund name: _____ Membership Number & Scale: _____

PERSON RESPONSIBLE & FAMILY DETAILS

PERSON RESPONSIBLE

Where a consumer is at any stage unable to give directions or necessary consents to medical and other care, Montefiore may obtain such directions and consents from the 'person responsible' for the consumer. A 'person responsible' is not necessarily the consumer's next of kin.

A 'person responsible' is either:

- A guardian who has the function of consenting to medical, dental and health care treatments or, if there is no guardian;
- A spouse or de facto spouse with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse;
- An unpaid carer who is now providing support to the person or provided this support before the person entered residential care; or if there is no carer:
- A relative or friend who has a close personal relationship with the person.

Who would be your 'Person Responsible'?

Name: _____ Relationship to you: _____

Address: _____ Postcode: _____

Phone Numbers: Home: _____ Business: _____ Mobile: _____

Email: _____

Will the person responsible pay your accounts? Yes No **If no, please provide details below:**

IN THE EVENT OF EMERGENCY PLEASE CONTACT

(an emergency is a **significant** change in the consumer's medical condition)

Name: _____ Relationship to you: _____

Address: _____ Postcode: _____

Phone Numbers: Home: _____ Business: _____ Mobile: _____

Do you wish this person to be contacted at any hour of the day or night? Yes No

If no, between what hours do you wish to be contacted? am _____ pm _____

POWER OF ATTORNEY / FINANCIAL MANAGER

A person can appoint another person Power of Attorney to execute documents and conduct financial and property matters on their behalf. Alternatively, a formal Financial Manager can be appointed by the Guardianship Tribunal.

Do you have a signed document for:

General Power of Attorney? Yes No Date of appointment: _____

Enduring Power of Attorney? Yes No Date of appointment: _____

Financial Manager via Guardianship Tribunal Yes No Date of appointment: _____

Name of person appointed: _____ Phone: _____

If yes a copy of this must be attached to this form.

GUARDIAN OR ENDURING GUARDIAN / ADVANCE CARE DIRECTIVE (LIVING WILL) OR TREATMENT PLAN

A person can appoint a Guardian or Enduring Guardian to make decisions in relation to accommodation and medical and other care should that person be unable to do so. Alternatively, a Guardian can be appointed by the Guardianship Tribunal.

Do you have a signed document for a:

Guardian? Yes No Date of appointment: _____

Enduring Guardian? Yes No Date of appointment: _____

Guardian via Guardianship Tribunal Yes No Date of appointment: _____

Name of person appointed: _____ Phone: _____

If yes, a copy of this must be attached to this form.

Do you have a Living Will? Yes No and/or **Advance Care Directive or Treatment Plan?** Yes No

- **If yes, a copy of this must be attached to this form.**

By signing this form, you undertake to advise Montefiore of any changes made to any of the above contracts and please send copies of all legal documents with your application.

DETAILS OF NEXT OF KIN (a person's closest living blood relative or relative by marriage / family) (If insufficient space, please attach separate list)

Spouse (if same as 'person responsible' write "as above")

Name: _____

Address: _____ Postcode: _____

Home Phone: _____ Business: _____ Mobile: _____

Occupation: _____ Name of Business: _____

Email address: _____

Children

1. Name: _____

Address: _____ Postcode: _____

Home Phone: _____ Business: _____ Mobile: _____

Occupation: _____

Email address: _____

2. Name: _____

Address: _____ Postcode: _____

Home Phone: _____ Business: _____ Mobile: _____

Occupation: _____

Email address: _____

3. Name: _____

Address: _____ Postcode: _____

Home Phone: _____ Business: _____ Mobile: _____

Occupation: _____

Email address: _____

Details of person to contact in case of emergency on Shabbat and high holy days

Name: _____ Telephone number: _____

CURRENT RESIDENTIAL AGED CARE FACILITY

Are you currently residing in another Aged Care Facility? Yes No

If yes, name of Facility: _____ Date of entry: _____

DOCTOR

General Practitioner: _____ Phone: _____

Address: _____ Postcode: _____

FUNERAL ARRANGEMENTS

IT IS VERY IMPORTANT TO COMPLETE THESE DETAILS AT THE TIME OF COMPLETING THIS FORM.

In the event of my death I require:

Burial with the Chevra Kadisha: Location: _____

Family will be Sitting Shivah: Yes No

Alternative funeral arrangements – provide details : _____

The Executor/s under my Will is/are: *(This is for the purpose of refunding the Refundable Accommodation Deposit and other financial arrangements.)*

Name/s: _____ Phone: _____

Address: _____ Postcode: _____

NON-SMOKING POLICY

Montefiore is a “smoke free” environment. Therefore, no consumer is permitted to smoke within the confines of the entire facility except in designated smoking areas outside the building.

FINANCIAL INFORMATION

Residential aged care fees and charges are strictly regulated by the Commonwealth Government and can vary depending on your financial circumstances. Information regarding your income and assets are required by the Residential Accommodation Department in order to determine the appropriate level of fees and charges.

INCOME and ASSETS

Total amount of pension received (include Australian & foreign pensions): \$ _____ per fortnight

If the pension noted above is a foreign pension please indicate which country: _____

Total amount of taxable income from all sources (excluding pension) \$ _____ per annum

Have you owned a home within the last two years? Yes No

If you still own a home, what is its market value? \$ _____

Is any money owed to the bank or anyone else on this property? Amount owing \$ _____

Do any of the following live in your home? Spouse Dependent Child Carer Close relative

Other: _____

How long has this person/s been living in your home? _____

Does this person/s receive or is eligible to receive an income support payment? Yes No

Estimated total value of assets (other than your home) owned or controlled by you directly or indirectly:

\$ _____



OTHER INFORMATION

Please supply any other information you feel we should be aware of, or anything you consider would assist us in support of your application?

PRIVACY CONSENT

For the purposes of your residence (or proposed residence) at Montefiore and the services we provide to you, we will need to collect, record and use personal information about you (including medical and financial information).

We may also sometimes need to disclose some of that information to:

1. Appropriate organisations, such as government departments (in Australia and, for some consumers, in other countries), hospitals and other homes or hostels to which you may seek to move; and/or
2. Medical practitioners, other health service providers, professional advisers and other appropriate persons, such as Guardians or other persons responsible under the *Guardianship Act NSW (1987)*.

In considering any disclosure to be made, we will bear in mind the maintenance of your privacy as an important criterion, subject to our need to perform our obligations and services.

By signing this form below, you signify your consent to our collecting, recording, using and disclosing, as we consider appropriate from time to time, personal information in relation to yourself. If you wish to limit any disclosure we may make, would you please delete "Nil" below and specify the limitations you require. Absence of consent may not necessarily preclude Montefiore from collecting, recording, using or disclosing such information.

A copy of the Organisation's full Privacy Policy is available from our office.

Limitations on Use or Disclosure (subject to the Montefiore Privacy Policy)

Nil

SIGNATURE AND DECLARATION

By signing this Application you declare that the information given in this form is true and complete, you give the undertaking set out above in relation to change to any Power of Attorney and/or appointment of Guardian or Financial Manager and you provide the privacy consent set out above.

Signature of Applicant

Date:

If this Application is being signed by an authorised signatory (e.g. Guardian, attorney or person responsible), please insert name of signatory below and attach a copy of the relevant authorisation document.

Name of Authorised Signatory