



APPLICATION FORM

Please complete all questions in this form

If you cannot answer either write 'Unknown' or 'Not Applicable' in the space provided.

Resident information

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

Surname: _____

Given Name(s): _____

Residential address: _____

Phone: Home: _____ Mob: _____

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

Marital Status: Single De facto Married Separated

Divorced Widowed Unknown

Former occupation: _____

Medicare Number: _____ Expiry Date: / / Ref No. on Card: _____

Private Health Fund: _____ Membership No. & Scale: _____

Respite ACAT Code: _____

Permanent ACAT Code: _____

Flu vaccination date: / /

COVID vaccination date: 1st dose / / 2nd dose / /

COVID vaccine type: AstraZeneca Pfizer Moderna

Other (please specify) _____

Your partner

Do you have a spouse or partner? Yes No

What is your spouse/partner's name?

Are you or your spouse/partner applying for a place together in aged care? Yes No

Does your spouse/partner already reside in an Aged Care Facility? Yes No

Current living arrangement

Own home Rental accommodation With family Hospital

Previous residential aged care facility

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

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

If yes, name of Facility: _____

Date of entry: / / _____

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 is your Person Responsible?

Name: _____

Relationship to you: _____

Address: _____

Postcode: _____

Phone Numbers: Home: _____

Bus: _____

Mob: _____

Email: _____

Will the Person Responsible pay your accounts? Yes No

If no, please provide contact details for accounts below.

Name: _____

Relationship to you: _____

Address: _____

Postcode: _____

Phone Numbers: Home: _____

Bus: _____

Mob: _____

Email: _____

In the event of emergency please contact

An emergency is a significant change in the consumer's medical condition (if same as Person Responsible, write 'As Above')

Name: _____ Relationship to you: _____

Address: _____ Postcode: _____

Phone: Home: _____ Bus: _____ Mob: _____

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

If no, during which hours do you wish this person to be contacted? _____

For observant Jewish consumers/representatives – alternative contact details in case of emergency on Shabbat and High Holy days.

Name: _____ Telephone number: _____

General Practitioner: _____ Phone: _____

Address: _____ Postcode: _____

Details of next of kin

This is the resident's closest living blood relative/s or relative/s by marriage/family – if insufficient space, please attach a separate list.

1. Name _____

Address: _____ Postcode: _____

Phone: Home: _____ Bus: _____ Mob: _____

Relationship to resident: _____ Occupation: _____

Email address: _____

2. Name: : _____

Address: _____ Postcode: _____

Phone: Home: _____ Bus: _____ Mob: _____

Relationship to resident: _____ Occupation: _____

Email address: _____

**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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Enduring Power of Attorney	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Financial Manager via Guardianship Tribunal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Name of person appointed:			Phone:

If yes to any of the above, copies of the relevant documents must be attached to this form.

**Guardian or Enduring Guardian/
Advance Care Directive 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Enduring Guardian	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Guardian via Guardianship Tribunal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Restrictive Practices Decision Maker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appointment date: / /
Name of person appointed:			Phone:

If yes to any of the above, copies of the relevant documents 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 to any of the above, copies of the relevant documents 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.

**Financial information/
income and assets**

Self-funded retiree Full aged pension Part aged pension Third party

Workers' compensation Dept of Veterans Affairs (specify type):

Other (specify):

Pension Number: Expiry Date:

Will/executor information

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

Name: _____ Phone: _____

Address: _____ Postcode: _____

Religious information

Montefiore is a Jewish communal not-for-profit organisation and our residential care campuses follow the Jewish Sabbath and festivals in a communal way. We are committed to the ideal of Spiritual and Cultural safety for all consumers, and to providing support to consumers of all faiths and backgrounds through our understanding and adoption of principles as outlined in the Aged Care Quality Standards. Montefiore understands that spirituality is not just religion or pastoral care and our philosophy supports respect, acceptance, empathy and inclusion for all consumers.

Religion: _____

If Jewish:

Applicant's Hebrew Name: _____

Mother's Hebrew Name: _____

Father's Hebrew Name: _____

Are you a Holocaust Survivor? Yes No

Are you a Child Holocaust Survivor? (born 1928–1944) Yes No

Are you a second-generation Holocaust Survivor? Yes No

Funeral details

In the event of my death I require (please ensure you complete these details at the time of completing this form):

Funeral Director:

Location: _____

For Jewish Residents – will the family be sitting shivah? Yes No

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.

I agree to comply with Montefiore's non-smoking policy Yes No

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 seek your consent to the intended uses and disclosures of information where appropriate 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). As required to any third party including external service providers to claim for their services.

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 Other (specify):

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/Authorised Signatory:

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:
