

APPLICATION FOR ACCOMMODATION

SITE	Kew Gardens Banfields		
PERSONAL	Full name of person applying for residency:		
INFORMATION	Preferred Name:		
	Date accommodation required: Applicants date of birth:		
	Accommodation required: Permanent Respite		
	Gender: Male Female Other		
	Where is applicant currently residing? Home Aged Care Facility Retirement Village Other		
	Pensioner Status: Full Part Non-pensioner Pension Number:		
	Select the Medicare card number and enter the 10 digit Medicare card number as shown on the Medicare card, and the person's individual reference number (IRN). The IRN is the number to the left of the name of the person on the Medicare card you are using for your search. Medicare Card Number:		
	Expiry:		
	IRN: DVA File Number:		
	Health Fund Name: Health Fund Number:		
	Level of Care:		
	Ambulance Cover Number:		
	If applicable, what is your PBS Safety Net Card Number?		
	Has the applicant been assessed by an Aged Care Assessment Team? Yes No		
	Please provide details of the Doctor who will be providing the applicant with medical care whilst at this facility: Drs Name:		
	Address:		
	Telephone:		
	Alternatively, would you like us to suggest a medical practitioner? Yes No		

REPRESENTATIVE	Full Name of Nominated Representative:			
INFORMATION	Relationship:			
	Address:			
	Suburb:	Postcode:		
	Telephone:	Mobile:		
	Email:			
	Is the Person:	Power of Attorney Guardian Admin	nistrator	
	Advocate	Other (please specify):		
	If the applicant is approved, Name of person to be contacted:			
	Phone:	Fax:		
	REPRESENTATIVE SIG	GNATURE:		
	DATE:			
FINANCIAL INFORMATION		ermanent or respite resident in another residential age	ed care	
	facility?			
	Yes (please tick one below)			
	No If yes, please provide details of facility. Facility Name:			
	Address:			
	Suburb:	Postcode:		
	Phone:	Fax:		
	Have you paid, or agreed to pay, an accommodation payment charge at another facility? Yes No			
		ommodation charge, how much was the charge: \$	nor day	
OTHER COMMENTS		- IIIII00dation charge, now much was the charge. φ	per day	
OTHER COMMENTS				
		OFFICE USE ONLY		
		CARE RECIPIENT I.D.:		

ADMISSION MANAGER:

DATE:

NAME:

SIGNATURE: