Your application

Applicant's name:

Please complete this form and return, either by mail or drop-off or please download and email to the customer service officer at your chosen Care Community.

Opal HealthCare

A guide to completing your application

Thank you for considering Opal HealthCare as a partner in your aged care. We are committed to bringing you joy during this important stage of life by offering you the opportunity to continue a life of purpose and meaning.

So that we can review your application and determine if we are suited to meet your personal needs, **please ensure you have:**

- [ ] Read the Privacy Statement, which is detailed at the end of this form
- [ ] Completed your application form by filling in all relevant questions and ticking any boxes that apply to you
- [ ] Included a copy of your ACAT assessment or referral code. If you don't have a copy, please let us know so we can obtain a copy on your behalf
- [ ] Included a copy of your Income and Assets Determination Letter from the Department of Human Services or DVA (if you have one)
- [ ] Included a certified copy of a Power of Attorney (if you have one)
- [ ] Included copies of Medicare card, Pension card, private health fund card

How do I submit my application?

Once you have completed your application, please hand it to the Customer Support team member at your chosen Care Community. If you would prefer to mail or scan your application form and documents, please call the team in your Care Community for the relevant details.

What happens next?

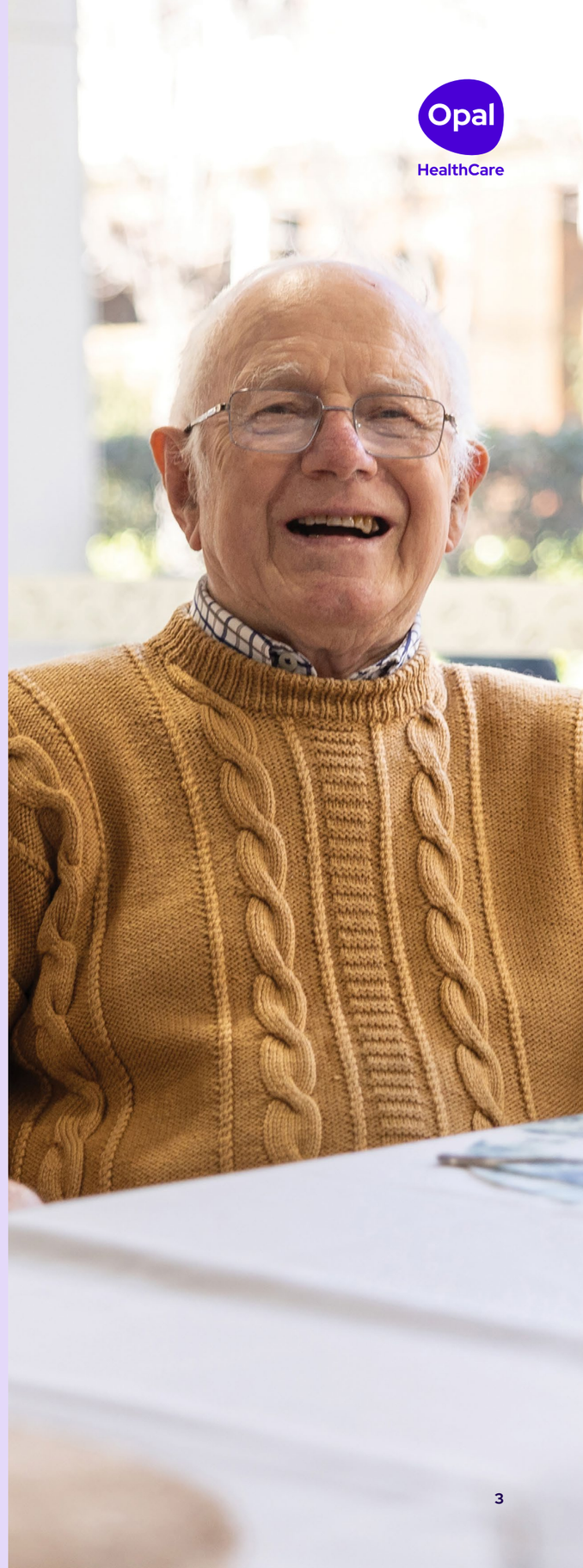
As soon as we receive your application, we will review the information to determine whether or not the Care Community you have chosen is able to meet your needs and requirements. If we are unable to accommodate you, we will either refer you to another of our Care Communities or direct you to an alternative aged care provider.

How will I be notified?

The team in your chosen Care Community will call you to discuss your application. However, as always, if you have any questions along the way, please do not hesitate to call us.

Can I be placed on a wait list?

If the Care Community you have selected is able to meet your clinical needs but does not have an appropriate bed available, we will ask you if you wish to be placed on a wait list.



Your Application

Date of application

D D M M Y Y Y Y

Placement required:

- Permanent
- Respite care
- Self-funded short term
- Self-funded long term

- I am applying for myself
- **Someone is applying on my behalf**
  - They are my registered representative/EPOA
  - They are my registered supporter

My preferred Opal HealthCare Care Communities are:

1.
2.
3.
- I don't have a preference

Things that are important to me about my care:

1.
2.
3.
4.

Things that are important to me in daily life:

1.
2.
3.
4.

About you: The person requiring residential aged care

Title — Mr — Mrs — Ms — Other

Surname

Given name(s)

Current residential address

Street number — Street name

Suburb — State — Postcode

Phone (Day) — Phone (Night)

Mobile — Email

Date of birth

D D M M Y Y Y Y

Gender

Marital status — Single — Married — De facto — Widowed — Divorced

No. of children

Country of birth

Aboriginal/Torres Strait Islander — Yes — No

Preferred language — English — Other (specify)

Require an interpreter — Yes — No

Name of someone who can assist with interpreting if necessary:

Phone — Email

Your religion — Do you smoke: — Yes — No

Previous occupation

Your partner

Do you have a spouse or partner? ☐ Yes ☐ No

Spouse/partner name

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

Does your spouse/partner already live in a residential care home? ☐ Yes ☐ No

Name and address of aged care home

Your pension status

Pension status ☐ Full pension ☐ Part pension ☐ No pension

Pension from ☐ Centrelink ☐ Department of Veterans Affairs (DVA) ☐ Other

Type of pension (e.g. age, disability etc.)

Pension number Card expiry date

DVA number Card expiry date

☐ Red ☐ Blue ☐ Gold ☐ White ☐ Other

Your health care

Name of your General Practitioner

Postal address

Phone number Email

Medicare card no. Expiry date Reference no.

If you have private health insurance, please complete:

Name of fund Membership number

Level of cover Do you have ambulance cover? ☐ Yes ☐ No

Your current situation

☐ I am currently at hospital

Name of hospital

Social worker/discharge nurse

Estimated discharge date

Your current specialist care requirements

☐ Mobility assistance
☐ Cognitive support
☐ Assistance with meals
☐ Wound management
☐ PICC or IVAB
☐ Nasal gastric or PEG
☐ ESBL or MRSA infection
☐ Bariatric care
☐ Secure dementia care
☐ Palliative care
☐ End of life care

Your initial care priorities

☐ Reablement
☐ Support & assistance
☐ Specialist clinical care
☐ Retaining my independence
☐ Happiness
☐ Longevity
☐ Dementia support
☐ End of life care

Your living arrangements

Where do you live? ☐ Own home ☐ Rented home ☐ Hospital ☐ With family/friends ☐ Retirement village ☐ Other residential aged care

Who do you currently live with? ☐ Spouse/partner ☐ Alone ☐ Carer ☐ With family/friends ☐ Dependent person

Are you currently living in residential aged care? ☐ Yes ☐ No

If yes, please specify which aged care home

Address of current aged care home

Telephone number of current aged care home

Is your current care ☐ Respite ☐ Permanent

Date you entered current aged care home

D D M M Y Y Y Y

Your previous aged care experiences

Have you ever been a resident in residential aged care in the past? ☐ Yes ☐ No

If yes, please indicate whether ☐ Respite ☐ Permanent

If respite, how many days of respite have been used since 1 July of this year?

Name of previous aged care home

Date of entry

D D M M Y Y Y Y

Your home care experience

☐ I have never been approved for home care

☐ I have been approved for home care Date of approval

Your eligibility for residential aged care

Have you been assessed by an Aged Care Assessment Team (ACAT/ACAS) as eligible for residential aged care services?

☐ Yes (Please attach a copy of your NSAF assessment or Aged Care Client)

Respite referral code

Permanent referral code

If you have not yet arranged an Aged Care Assessment, please contact My Aged Care on 1800 200 422 or visit myagedcare.gov.au

Nominated contacts

Whenever possible, we will always talk to you, about the care and services we provide to you. However, we ask that you please nominate a trusted person/s whom we can contact if necessary.

Primary contact details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Other

Full name

Relationship to you

Primary contact's residential address

Address

Suburb State Postcode

Primary contact's phone number

Day Night

Mobile Email Address

☐ This is a registered support person

Secondary contact details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Other

Full name

Relationship to you

Secondary contact's residential address

Address

Suburb State Postcode

Secondary contact's phone number

Day Night

Mobile Email Address

☐ This is a registered support person

Billing

Who should receive bills related to your care?

☐ I should (the resident) ☐ Primary contact ☐ Secondary contact

☐ Other contact (please complete below)

Preferred delivery ☐ Email ☐ Post

We appreciate your support in helping us to move towards environmentally-friendly electronic statements. Hard copy statements incur a $1 per month handling fee.

☐ **A third party is paying for my fees**

Type of third party ☐ Department of Veterans Affairs ☐ NDIS ☐ Home care ☐ Other

Home care provider Other

Billing contact details

Full name

Relationship to you

Organisation name (if applicable)

Phone number Email address

Your legal details and preferences

Please make sure that you have supplied certified copies of the relevant documentation to support details specified below.

Do you have a power of attorney(s) or guardianship? ☐ Yes ☐ No

Document description

Full name and phone number of person appointed under the document

Please note that the scope of authority granted varies depending on the type of document and the jurisdiction.

☐ Certified copy of relevant document attached

Signature

Name of person requiring residential aged care

Signature

If an authorised person is signing for the resident:

Name of authorised person

Signature

Capacity/authority of person?

Date

D D M M Y Y Y Y

Please return this form to the Care Community you are applying to. Alternatively, please call **1300 362 481** or email us at **communications@opalhealthcare.com.au**

Privacy Statement

The personal information provided in this application and in any subsequent resident related documents is collected by DPG Services Pty Ltd (ABN 38 090 007 999) trading as Opal HealthCare for the purposes of assessing and processing the application and, in the event a resident agreement is signed, facilitating and administering the care and services to be provided to the resident and all related payments, accounts and billing. Without this information Opal HealthCare may not be able to assess and process the application. Please refer to Opal HealthCare's Privacy Policy available at ***opalhealthcare.com.au/privacy-policy*** for further information about how Opal HealthCare uses personal information collected by it, who does it disclose it to, how it can be accessed and corrected and how to make a complaint about its handling by Opal HealthCare. By signing this application you confirm that you are authorised to provide to Opal HealthCare all personal information included in it in relation to the resident, their relatives and contact persons.