TORBAY Lifestyles and Care Limited
(ABN 33 010 200 567 ACN 010 200 567)

43 Exeter Street, Torquay
P.O. Box 492
Hervey Bay, Qld, 4655
Phone: 07 4125 0800
Fax: 07 4125 0813
Email: admin@torbay.org.au

THANK YOU FOR YOUR INTEREST IN TORBAY LIFESTYLES AND CARE

To make an application please complete and return the following forms:

- Application for care
- Pre-admission Summary
- Privacy Collection Statement
- Direct Debit
- Medication Administration Consent
- Media Consent
- Pharmacy Application

Please return your completed forms to:

Admissions Officer
Torbay Head Office
43 Exeter St Torquay 4655
Fax: 4125 0813
Email: admin@torbay.org.au

Please enclose the following with your application:

- **CERTIFIED COPY** of Enduring Power of Attorney (EPOA)
- Copy of Aged Care Assessment (ACAT) or referral codes

If you do not have an Aged Care Assessment (ACAT) you can make a referral to have one done by contacting My Aged Care on 1800 200 422

AGED CARE FEES:
Please see enclosed Department Schedule of Fees and Charges

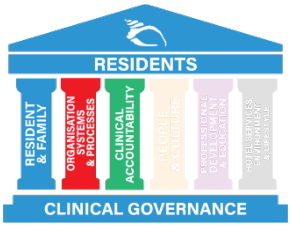
RESPITE CARE – Basic Daily Fee only (not means tested)

PERMANENT CARE - These fees are calculated by the Government depending on your assets and income. Please complete the enclosed form - REQUEST FOR A COMBINED ASSETS AND INCOME ASSESSMENT and return it to Centrelink or DVA as soon as possible. The outcome can take up to 8 weeks. The return address is on page 2 of the form.

If you have any questions please do not hesitate to call me.

Kind Regards

Jenni Thompson
Admissions Officer



AF01 – APPLICATION FOR ADMISSION

Distribution: 1. Original to Administration Residents File 2. Copy to Care Section

Surname:	Given Names:
Preferred Name:	Date of Birth:
Date of ACAT:	Admitted from:
Date of Admission (Permanent):	Date of Admission (Respite):
Type of ACAT Approval: ☐ Permanent ☐ High Respite ☐ Low Respite	
Do you receive any other Government Funding/Support?	
Person Completing the Application	
Name:	
Address:	
Contact Details:	
Relationship to the applicant:	
Medical Practitioner Details	
Name:	
Address:	
Phone:	Mobile:
Medicare & Health Insurance Details	
Medicare No.:	Card Expiry:
Health Fund (name):	Health Fund No.:
Pension & Benefit Details	
Full-Pensioner Part Pensioner Non-Pensioner	
Pension No. / DVA No.:	Concession Card No.:

Personal Details	
Marital Status: Single Married Widowed Divorced DeFacto	
Country of Birth:	Preferred Language(s):
Interpreter Needed: Yes: No	
Religion / Organisational Affiliations:	
First Contact	
Name:	Relationship:
Address:	
Postcode:	Phone (Day):
Phone (After Hours):	Mobile:
Second Contact	
Name:	Relationship:
Address:	
Postcode:	Phone (Day):
Phone (After Hours):	Mobile:
Legal & Financial Management Details	
Enduring Power of Attorney (EPOA): Yes (Copy Attached) No	
Details:	
Guardian:	Financial Administrator:
Advanced Heath Care Directive: Yes (Copy Attached)	
Have you made a will: □ Yes □ No If yes, please provide details:	
Funeral Director Preferred (Name & Contact Details):	Burial Cremation

THE FOLLOWING FINANCIAL DETAILS ARE NOT REQUIRED IF A STATEMENT OF RESIDENT STATUS FOR RESIDENTIAL AGED CARE PROVIDERS FROM CENTRELINK OR DEPARTMENT OF VETERANS AFFAIRS HAS BEEN ATTACHED TO THIS APPLICATION. NOT REQUIRED IF THIS APPLICATION IS FOR RESPITE CARE ONLY.

It is not compulsory for new residents to have an assets assessment UNLESS they wish to claim supported resident status. Residents can negotiate to pay an agreed accommodation bond without having an assessment or the result of this assessment can be used to negotiate the amount of the accommodation bond.

Residents who are eligible to pay an accommodation charge can be asked to pay the maximum charge rate if they have assets above the upper assets threshold or they do not have an assets assessment.

Property assets

The following information is required to enable us to determine whether the applicant will be requested to pay an Accommodation Bond or Charge.

Did you own or part own the house, unit or flat in which you normally live in the last two years?

□ Yes □ No

If Yes, please provide the following information in regard to the property:

Address:_____

Current Market Value of Property: $ _____

Your home may be excluded

Please answer the following questions :

Do you have a spouse or dependent child living in your home? □ Yes □ No

Have you had a carer who is eligible for a pension or other support payment living in your home for at least the past two years?

□ Yes □ No

Have you had a close relative who is eligible for a pension or other income support living in your home for at least five years?

□ Yes □ No

Have you disposed of any property in which you were living in the past two years?

□ Yes □ No

Do you own, or part own any other residential or commercial property?

□ Yes □ No

Have you any loans to repay? □ Yes □ No

If Yes, please give details $ _____

Previous Aged Care Residential Accommodation details:

Have you paid an entry contribution or accommodation bond/charge to another facility? □ Yes □ No

If yes, please provide the following details:

Name of Facility:_____

Address:_____

_____ Postcode: _____

Telephone: _____

Date of Admission to first facility: _____

ASSETS	YOURS $	YOUR PARTNER'S $	JOINT $
Annual Pension Amount			
Bank Accounts			
Building Society & Credit Union Accounts			
Interest Bearing Deposits & Fixed Deposits			
Bonds; Debentures & Shares			
Investments in Property Trusts; Friendly Societies; Equity Trusts; Mortgage Trusts & Bond Trusts			
Superannuation Assets from which lump sums may be withdrawn			
Home – Market Value			
Real Estate (net after any charges) includes properties you own outside Australia			
Businesses			
Farm Property (net after any charges)			
Loans to Others (including interest free loans & monies owed to you)			
Motor Vehicles; Boats and Caravans			
Investment Collections (including coins and stamps)			
Household Contents & Personal Items – taken as $5,000 per household (unless stated otherwise)			
Surrender Value of Life Insurance Policies			
Any other Assets (including entry contribution / accommodation bond refunds due)			
TOTAL VALUE OF ASSETS			
LESS LOANS TO BE REPAID			
NET ASSETS $			

Name of Person Completing Application: _____

Signature: _____

Date: _____

AF03 – PRE–ADMISSION SUMMARY

RESIDENT'S NAME: _____

DATE OF BIRTH: _____

NAME OF REGULAR GP: _____ PHONE NO: _____

INFORMATION RECEIVED FROM: _____

PHONE NO: _____

CURRENT HEALTH ISSUES:

_____

_____

SIGNIFICANT PAST HISTORY:

_____

_____

CURRENT MEDICATIONS:

_____

_____

Does Resident require assistance with taking medication?
☐ Yes ☐ No

Does Resident have any allergies?
☐ Yes ☐ No

List of allergies and effects (if relevant):

_____

_____

Do you suffer from: Chest Pain Palpitations Anemia Cyanosis Hypertension or Breathlessness

Does the Resident have any form of Dementia?

Yes No

Does Resident have any cognitive impairment? Yes No

Mild Moderate Profound

Does the Resident have a history of?

Wandering Verbal Aggression Physical Aggression Confusion Agitation

Does the Resident have any form of Depression?

Yes No

BATH / SHOWER

Is the Resident able to shower themselves?

Yes No Requires Supervision / Assistance

Do they require assistance with?

Washing Drying Cutting / Cleaning of Nails

Combing Hair Cleaning Teeth Shaving

Is the Resident able to dress themselves?

Yes No Requires Supervision

If NO, do they require assistance with:

Dressing Undressing Selecting Clothes Footwear

CONTINENCE

Does the Resident have bladder incontinence?

Yes No

Does the Resident have bowel incontinence?

Yes No

TOILETING

Is the Resident able to take themselves to the toilet?

Yes No Requires Supervision / Assistance

Do they require?

Supervision with clothing adjustment or cleaning themselves

Assistance with clothing adjustment or cleaning themselves

Do they wear Continence Aides?

Yes No

MOBILITY /TRANSFERS

What is the resident's/consumer's level of mobility?

Normal Gait Unsteady Gait Non weight Bearing

Has the Resident had any falls recently? Yes No

Details: _____

_____

Do they require Mobility Aides? Yes No

Walking Stick Wheelie Walker Wheelchair

Do they require assistance with transfers? Yes No

If yes, describe level of assistance:

COMMUNICATION

Does the Resident have vision impairment?

Yes No Comments: _____

Does the Resident have a hearing impairment?

Yes No Comments: _____

Does Resident have speech impairment?

Yes No Comments: _____

SPECIALISED NURSING CARE NEEDS:

Does the Resident have any of the following?

Wound Care Blood Glucose Monitoring Dialysis Treatment

Tube Feeding Oxygen Therapy Compression Stockings

Syringe Driver Colostomy or Ileostomy Care Catheter Care

If YES, please provide details: _____

_____

PAIN:

Does the Resident have any current pain of discomfort?

Yes No

Current Treatment: _____

NUTRITION:

Does the Resident have any of the following dietary requirements?

Soft Cut-Up Minced Moist Vitamised

Does Resident have any swallowing difficulties?

Yes No

Does Resident require thickened fluids?

Yes No

Does the Resident have a history of smoking?

Yes No Still Smokes

Daily intake of alcohol: _____

Comments:

What is the Resident's current: Height: _____ Weight: _____

Comments on the resident's General State of Health:

_____

_____

_____

Name of Person Completing Application:

_____

Signature: _____ Date: _____