KANANDAH RETIREMENT LIMITED
21 DOURO STREET MUDGEE NSW 2850
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KANANDAH
EXCELLENCE IN AGED CARE

CONSUMER'S ADMINISTRATION DETAILS FORM

PLEASE NOTE: **Due to the large number of applications Kanandah receives, this form will only be held for a period of SIX (6) MONTHS from the date of receipt.**

A new application will be required thereafter, if the applicant wishes to remain on the waiting list.

APPLICANT DETAILS:

First Name:

Last Name:

Other Names:

Preferred Name:

Date of Birth: Day / Month / Year

Date of Application: Day / Month / Year

Gender: ☐ Male ☐ Female ☐ Other

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other _____

Marital/Partnership status: ☐ Married ☐ Single ☐ Widowed ☐ DeFacto ☐ Other _____

Pre-Admission Home Address:

Applicants Address Details: Address State Post Code

Applicants Email Address:

Applicants Home Phone Number: Mobile:

Current /Former Occupations:

Religion/belief:

Country of birth:

Language(s) usually used:

DETAILS OF PERSON/S MAKING APPLICATION FOR CONSUMER

Contact Name:

Relationship to Applicant:

Contact Details: Home Phone: | Work Phone: | Mobile Number:

Address Details: Address | State | Post Code

Email :

TYPE OF ACCOMMODATION

☐ Hostel OR ☐ Self Care OR ☐ Memory Support

☐ Permanent OR ☐ Respite

OFFICE USE ONLY: ☐ High Care OR ☐ Low Care

AGED CARE ASSESSMENT DETAILS

Has the applicant been assessed by the Aged Care Assessment Team (ACAT)? ☐ Yes ☐ No

Dated: Day / Month / Year

Referal Code

Respite

Permanent

MEDICARE DETAILS

Medicare Number:

Medicare IRN:

(This is the number before the person's name on the card)

Medicare No Expiry Month/Year: Month / Year

PENSION DETAILS

Is the applicant a retired veteran/DVA client? ☐ Yes ☐ No

DVA Number:

Pension Number:

Australian full pension: ☐ Yes ☐ No ☐ N/A ☐ Other _____

OR

Australian part pension: ☐ Yes ☐ No ☐ N/A ☐ Other _____

Expiry date of Australian pension - Month/Year: Month / Year

**** ADDITIONAL INFORMATION FOR WAITING LIS

Has the aged care assessment been completed? ☐ Yes ☐ No ☐ N/A

Is there an approval? ☐ Yes ☐ No ☐ N/A

Date approval granted: Day / Month / Year

NEXT OF KIN DETAILS - ACTING ON BEHALF OF CONSUMER/ABLE TO DISCUSS CONSUMER'S PERSONAL INFORMATION

FIRST NEXT OF KIN

Relationship to Applicant:

Name of Next of Kin:

Address Details: Address State Post Code

Email :

Mobile Number:

Home Phone Number: ( )

SECOND NEXT OF KIN

Relationship to Applicant:

Name of Next of Kin:

Address Details: Address State Post Code

Email :

Mobile Number:

Home Phone Number: ( )

EMERGENCY CONTACTS
(if different from Next of Kin)

Emergency Contact 1:

Name:

Address: Address State Post Code

Phone Numbers: Home Phone: Work Phone: Mobile Number:

Emergency Contact 2:

Name:

Address: Address State Post Code

Phone Numbers: Home Phone: Work Phone: Mobile Number:

HEALTH FUND DETAILS

Health Fund:

Membership No:

POWER OF ATTORNEY'S/BILLING DETAILS

Is consumer able to manage their own affairs: ☐ Yes ☐ No ☐ N/A

POWER OF ATTORNEY - FINANCIAL

Has a Power of Attorney - Financial, been approved: ☐ Yes ☐ No ☐ N/A

If YES, then

Full Name:

Address: Address State Post Code

Telephone Contact for person responsible for financial affairs: Home Phone: Work Phone: Mobile Number:

Email of person responsible for financial affairs:

PLEASE PROVIDE A COPY FOR OUR RECORDS

ENDURING POWER OF ATTORNEY - MEDICAL

Has a Power of Attorney - Medical, been approved: ☐ Yes ☐ No ☐ N/A

If YES, then

Full Name:

Address: Address State Post Code

Telephone Contact for person responsible for medical affairs: Home Phone: Work Phone: Mobile Number:

Email of person responsible for medical affairs:

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LEGAL GUARDIAN

Has a Guardian been approved: ☐ Yes ☐ No ☐ N/A

If YES, then

Full Name:

Address: Address State Post Code

Telephone Contact: Home Phone: Work Phone: Mobile Number:

Email :

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ADMINISTRATOR

Has an Administrator been appointed: ☐ Yes ☐ No ☐ N/A

If YES, then

Full Name:

Address: Address State Post Code

Telephone Contact: Home Phone: Work Phone: Mobile Number:

Email :

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MEDICAL CONTACT DETAILS

Medical Practitioners name:

Address: Address State Post Code

Contact telephone number: ( )

Fax Number: ( )

ALLERGIES / SENSITIVITIES

Drug allergies (and type of reaction details):

Drug sensitivities:

Food/fluid allergies (and type of reaction details):

Food allergies (and type of reaction details):

Food sensitivities:

Other allergies (and type of reaction details):

Other sensitivities:

Food preferences: (please name your favourite foods)

Food dislikes: (please name any foods you don't like)

FUNERAL DIRECTOR DETAILS

Nominated funeral director:	

DETAILS OF VALUABLES TO BE LODGED

SPECIAL CLOTHING/FOOTWEAR

Details re special clothing items eg Fur coat:	
Details re special footwear eg orthotics :	

JEWELLERY/MOMENTOS

Consumers are encouraged to leave valuable items with family/friends or if necessary in Kanandah's safe located in the Administration Building.

Please note: Consumers are responsible for the care of all items of jewellery and other valuables located at Kanandah. Consumers are also responsible for the insurance of any valuable jewellery or items located at Kanandah.

Details re ring/s (note - specify colour of stones and ring metal):	
Details re necklaces (note - specify colour of stones and ring metal):	
Details other jewellery items eg watch, earrings:	
Details of other treasured items in consumer room:	

Photograph's of each item will be taken and a copy provided to the consumer and a copy retained on file.

PERSONAL EFFECTS/EQUIPMENT DETAILS

☐ Television/DVD etc	Details:
☐ Bar Fridge	Details:
☐ TV Table/Cabinet	Details:
☐ Furniture eg bed, bedside tables etc	Details:
☐ Chair	Details:
☐ Mobility Aids	Details:
☐ Glasses, Hearing Aid, Dentures	Details: (It is preferred that these items are engraved prior to admission)
☐ Other items	Details:

PERMISSION TO DISPLAY NAME AND PHOTOGRAPH

I give permission for my name and photograph to be displayed on the Directory Board at the entrance of the Hostel and on the Kanandah website.	☐ Yes ☐ No

APPLICATION

Name of person completing application:	
Signature and Date:	Date:

Thank you for your information. Your application will be held for 6 months from the date above.

HAVE YOU COMPLETED ALL DOCUMENTATION?

☐ Medication Forms	Has the yellow folder been given to your Doctor for completion and given back to Kanandah?
☐ Advance Care Directive	
☐ Good Food Handling Practices	
☐ Direct Debit Request	
☐ Electoral Roll	If this is a permanent placement, have you completed the Electoral Roll Form indicating change of address? If not, this must be done prior to being admitted to Kanandah.
☐ Has an account to be set up at Blooms the Chemist?	
☐ Consumer Agreement	Has this document been signed and lodged with the Finance Manager

OFFICE USE ONLY

Agreed date of entry to Kanandah:

Anticipated Room Number, if known:

If transfering from another facility: ☐ Yes ☐ No

If YES, then

Facility Name:

Address: Address State Post Code

Date residential aged care commenced: Day / Month / Year

Phone Number: ( )

Contact Person:

Name of ACAT Assessor:

Contact Number: ( )

Consumer UR No:

Government No:

ACAT Expiry Date: