



Algerter Lodge

117 Dalmeny Street
Algerter Qld 4115

Email: admissions@algerterlodge.com

Phone: 0418 117 906

Bundaleer Lodge

114 Holdsworth Rd
North Ipswich Qld 4305

admissions@bundaleerlodge.com

Application for Respite Accommodation

Privacy Policy

The information collected in this residency application is for the primary purpose of assessing eligibility for residency at Algerter Lodge/Bundaleer Lodge. The information will only be used for the purpose for which it was collected. The resident information is confidential and will not be disclosed to any third party without the resident's written permission.



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Personal Data – Application for Residency

<p>Name – what is the full name of the person applying for residency?</p>	<p>Title: Mr/Mrs/Miss/Ms Surname: Given Names:</p>
<p>Address – Insert current address</p>	<p>.....</p>
<p>Date of Birth – what is the applicant’s date of birth and age?</p>	<p>DOB:/...../..... Age:years</p>
<p>Marital Status – what is the applicant’s marital status?</p>	<p>Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/></p>
<p>Religion – what is the applicant’s religion?</p>	<p>.....</p>
<p>Country of Birth – what is the applicant’s country of birth and preferred spoken languages?</p>	<p>Country of Birth: Preferred Language:</p>
<p>Assessment – has the applicant been assessed by an Aged Care Assessment Team? If so what is the care status level - low care/high care?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Low care <input type="checkbox"/> High Care <input type="checkbox"/> Dementia Specific <input type="checkbox"/> Please attach a copy of the assessment or provide approval reference number.</p>
<p>Financial Affairs – who will be responsible for managing the resident’s financial affairs?</p>	<p>Title: Mr/Mrs/Miss/Ms Name: Address: Telephone: Relationship: Email:</p>



Algester Lodge

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<p>Pension</p> <p>Does the applicant receive a pension?</p> <p>Does the applicant have a pension card issued by Centrelink?</p> <p>Does the applicant have a pension card issued by Veterans Affairs?</p>	<p>Yes Full Pension <input type="checkbox"/> Yes Part Pension <input type="checkbox"/></p> <p>No Pension <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Pension Number:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Veterans Affairs Number:</p>
<p>Medicare – does the applicant have a medicare card?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Medicare No:</p> <p>Expiry Date:</p> <p>Number on Card:</p>
<p>Doctor – what is the name and telephone number of your current doctor?</p> <p>Will your doctor or locum service be available 24 hours per day to provide you with medical care whilst at this facility?</p>	<p>Name:</p> <p>Telephone Number:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, the facility will appoint a GP. Facility appointed GP name and number:</p>
<p>Funeral Arrangements – what are the applicant’s funeral arrangements?</p>	<p>Name of funeral director:</p> <p>.....</p> <p>Address:</p> <p>.....</p> <p>.....</p> <p>Telephone:</p> <p>Burial <input type="checkbox"/> Cremation <input type="checkbox"/></p> <p>Other:</p> <p>.....</p> <p>.....</p> <p>.....</p>



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<p>Nominated Representative – who will be the applicant’s nominated representative? (The facility will consult this person in relation to matters relating to care, change of condition etc.)</p>	<p>Title: Mr/Mrs/Miss/Ms Name: Address: Telephone: Relationship: Email:</p>
<p>Previous Respite Care – if applicable please insert details of previous respite care.</p>	<p>Number previously taken respite days Name of facility where respite care days taken Documentary evidence provided for respite days taken Yes <input type="checkbox"/> No <input type="checkbox"/> Document name:</p>
<p>Current Respite Care</p>	<p>Date of Admission Date of Vacating Total Number of Days:</p>
<p>Enduring Power of Attorney – has the applicant an Enduring Power of Attorney?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach a copy. Title of Attorney: Mr/Mrs/Miss/Ms Name: Address: Telephone: Relationship: Email: If no, please insert details of your statutory health attorney. Title of Attorney: Mr/Mrs/Miss/Ms Name: Address: Telephone: Relationship: Email:</p>



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<p>Relevant Medical History – please provide details of medical history incorporating any surgical and psychological history.</p> <p>Please supply letter from doctor/specialist/hospital discharge.</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>Current Medication – please provide details of all medication taken by the applicant.</p> <p>Please have doctor complete Medication Chart.</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

Signature of Person Completing this Form :

Print Name clearly:

Date Form Completed:/...../.....