U.P.A. RIVERINA MURRAY REGION
AGED CARE SERVICES

Application for Residency

UPA Murray River Region
342 Wagga Road
(P.O. Box 123)
LAVINGTON N.S.W. 2641
Phone: 02 6025 1776
Fax: 02 6025 5712

Our Mission

To offer care of the highest possible standard consistent with the UPA's Christian commitment and the expectations of society.

U.P.A. RIVERINA MURRAY REGION
AGED CARE SERVICES

Accommodation Details

Date of application: _____

Residential Status: ☐ Permanent ☐ Respite

Preferred Location:

☐ Murray Vale Shalem Hostel Lavington
☐ Myoora Homestead Hostel Henty
☐ Oolong Hostel Howlong
☐ Jindera Aged Care Hostel
☐ Holbrook Village Hostel
☐ Gumleigh Gardens Hostel

Personal Details

TITLE: (*please circle*) MR MRS MISS MS

FIRST NAMES: _____ SURNAME: _____

PRESENT ADDRESS: _____

_____

TOWN / SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ DATE OF BIRTH: _____

EMAIL ADDRESS FOR STATEMENTS: _____

Please provide the contact details of the person to contact in case of an emergency:

TITLE: (*please circle*) MR MRS MISS MS

FIRST NAMES: _____ SURNAME: _____

PRESENT ADDRESS: _____

_____

TOWN / SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ MOBILE: _____

RELATIONSHIP: _____

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Legal Information

LEGAL NEXT OF KIN: _____

RELATIONSHIP: _____

ADDRESS: _____

TOWN / SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ MOBILE: _____

DOES THIS PERSON HAVE AN ENDURING POWER OF ATTORNEY? ☐ YES ☐ NO

If NO, please state name and details of person with Power of Attorney:

NAME: _____

ADDRESS: _____

TOWN/SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ MOBILE: _____

IF YOU ARE APPLYING FOR RESPITE CARE YOU DO NOT NEED TO COMPLETE THE REST OF THIS APPLICATION

WHO IS YOUR SOLICITOR? _____

ADDRESS: _____

TOWN / SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ MOBILE: _____

WHERE IS YOUR WILL DEPOSITED OR CURRENTLY HELD?

Funeral Arrangements

Please state the name and contact details of the person responsible for making your funeral arrangements:

FUNERAL DIRECTORS NAME: _____

ADDRESS: _____

TOWN / SUBURB: _____ POSTCODE: _____

TELEPHONE: _____ MOBILE: _____

Note: A confidential Medical Report is required as part of your application. The form will be required to be completed when residency is available, please have your family doctor complete the form and return it to our UPA Regional Office, PO Box 123, Lavington.

_____ _____

SIGNED DATE OF SIGNATURE

RESIDENT ASSESSMENT - DATA BASE (page 1 of 5)

ADMISSION DATE:	**PERMANENT RESIDENT/ RESPITE RESIDENT CLIENT**
ALLERGIES:	
TO BE COMPLETED BY RESIDENT OR REPRESENTATIVE (at time of or prior to admission)	
FULL NAME	**PREFERRED NAME**
DOB	**PLACE OF BIRTH**
MARITAL STATUS	**NAME OF SPOUSE**
PREVIOUS ADDRESS	
NEXT OF KIN Name/address/phone/email	**PERSON RESPONSIBLE FOR AFFAIRS** Name/address/phone/email
CHOSEN DOCTOR Name/address/phone/email	**CHOSEN PHARMACY** Name/phone/email
MEDICARE NUMBER & EXPIRY DATE	**PENSION NUMBER**
PRIVATE HEALTH FUND **YES NO** please circle	**NAME OF HEALTH FUND & MEMBERSHIP No.**
RELIGION	**REQUEST FOR CLERGY TO VISIT** **YES NO** please circle
NATIONALITY	**DOMINANT LANGUAGE** **INTERPRETOR REQUIRED** **YES NO** please circle
GUARDIANSHIP ORDER IN PLACE **YES NO** please circle	**IS POWER OF ATTORNEY HELD** **YES NO** **What type:** **Name & contact No. of Person:** **Copy obtained: YES NO**
PROTECTIVE COMMISSIONER USED	**ADVANCED CARE DIRECTIVE IN PLACE** **YES NO** please circle
CURRENTLY ON ELECTORAL ROLL **YES NO** please circle	**WISHES TO REMAIN ON ELECTORAL ROLL** **YES NO** please circle

DATE: **SIGNATURE:**