

# Victorian Elderly Chinese Hostel 維省華族老人宿舍

## New Resident Application Form 長者住宿申請表

<b>(A) Resident Personal Details</b> 申請人個人資料	<input type="checkbox"/> Respite 暫住 <input type="checkbox"/> Permanent 長住
ACAT Residential Respite Code 養老院評估暫住代碼: _____	
ACAT Residential Permanent Code 養老院評估長住代碼: _____	
Surname 姓: _____ First Name 名: _____	
Chinese Name 中文姓名: _____ Sex 性別: <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	
Date of Birth 出生日期: ____/____/____ Country of Birth 出生地點: _____	
Language Spoken 語言: _____	
Current Accommodation 目前住宿: <input type="checkbox"/> Home 住所 <input type="checkbox"/> Facility 機構	
Address 住址: _____ Facility Name 機構名稱: _____	
_____ Contact Number 聯絡電話: _____	
_____	
<b>Residency Status 居留身份:</b> <input type="checkbox"/> Citizen 澳洲公民 <input type="checkbox"/> Permanent Resident 澳洲居民 <input type="checkbox"/> Others 其他 _____	
1st Contact Person 首聯絡人姓名: _____ Relationship 關係: _____	
Contact Number 聯絡電話: _____ Email 電子郵件: _____	
Address 住址: _____	
_____	
2nd Contact Person 次聯絡人姓名: _____ Relationship 關係: _____	
Contact Number 聯絡電話: _____ Email 電子郵件: _____	
Address 住址: _____	

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### (B) Pension and Benefit Details 養老金及社會福利資料:

Do you receive any form of income support payment?

有否收取任何形式的收入補助金?

Yes 是  No 否

Type of support payment 補助金類別:

Full Aged Pension 全額養老金  Part Aged Pension 半額養老金

Superannuation 退休金  Overseas Pension 海外養老金

Other 其他: \_\_\_\_\_

Pension Concession Card Number 養老金領取者優惠卡號碼: \_\_\_\_\_

Expiry Date 到期日: \_\_\_\_\_

Medicare Card Number 國民保健卡號碼: \_\_\_\_\_

Expiry Date 到期日: \_\_\_\_\_

### (C) Private Health Insurance 私人保險:

Private Health Insurer 私家醫療保險公司名稱: \_\_\_\_\_

Membership Number 會員卡號碼: \_\_\_\_\_

Ambulance Membership Card Number 救傷車會會員號碼: \_\_\_\_\_

### (D) Assets & Income assessment for Permanent Care from Centrelink

已向福利部申請入息及資產綜合評估?:

Yes 是  with report 已交報告  without report 未交報告

No 否

### (E) Information regarding Medical Diagnosis & Medications 病歷及服用藥物資料:

As per ACCR 夾附養老評估服務報告

As per medical referral letter 夾附醫生介紹信

Major medical conditions 健康狀況:

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Major medications 主要服用藥物:

GP visits 醫生探訪:  Own GP Dr \_\_\_\_\_

已有家庭醫生 \_\_\_\_\_

Requires facility arrangement 由院方建議  
Dr. Peter Ng/ Dr. Merran Pang/ Dr. Oliver Wu

Specialized nursing care needs e.g. Blood pressure, Blood glucose level, Catheter care, Wound care 註明專業護理需要, 如量血壓, 量血糖, 導管或傷口處理:

### Details of Activities of Daily Living needs 下列那一項日常生活需要協助

Eating & Drinking 飲食協助 <input type="checkbox"/>	Mobility 行動協助 <input type="checkbox"/>	Personal Hygiene 個人衛生協助 <input type="checkbox"/>	Toileting 如廁協助 <input type="checkbox"/>	Continenence Aids 失禁用品 <input type="checkbox"/>	Others 其他 <input type="checkbox"/>
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### Details of Behaviour / Social needs 行為/社交需要協助

Verbal disruption 言語滋擾他人 <input type="checkbox"/>	Wandering 遊蕩行為 <input type="checkbox"/>	Physical disruption 行動滋擾他人 <input type="checkbox"/>	Others 其他滋擾行為 <input type="checkbox"/>
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### Special Request 特別要求:

Dietary 膳食  Religious 宗教  Social 社交  Other 其他 \_\_\_\_\_

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### (F) Medical Decision Maker 医疗决策者:

**Medical Decision Maker 医疗决策者授權書:**  Yes 是  No 否

Name 委託人姓名: \_\_\_\_\_ Relationship 關係: \_\_\_\_\_

Contact Number 聯絡電話: \_\_\_\_\_ Email 電子郵件: \_\_\_\_\_

### (G) Legal and Financial Management Details 法律及財務管理資料:

**Power of Attorney (POA) 已申請持久授權書:**  Yes 是  No 否

General non-enduring power 普通授權書       Supportive attorney 支持授權書       Enduring power of attorney 持久授權書

Name 委託人姓名: \_\_\_\_\_ Relationship 關係: \_\_\_\_\_

Contact Number 聯絡電話: \_\_\_\_\_ Email 電子郵件: \_\_\_\_\_

If no POA appointed, authorize a nominee to be responsible for paying accounts and receiving correspondence from the Hostel and relevant Government Department(s).

如未能安排持久授權委託書，請填寫負責交費及代收由護理院或政府部門信件的授權人資料:

Name 授權人姓名: \_\_\_\_\_ Relationship 關係: \_\_\_\_\_

Contact Number 聯絡電話: \_\_\_\_\_ Email 電子郵件: \_\_\_\_\_

**Financial Guarantor 已委託財務擔保人:**  Yes 是  No 否

Name 擔保人姓名: \_\_\_\_\_ Relationship 關係: \_\_\_\_\_

Contact Number 聯絡電話: \_\_\_\_\_ Driver's License 駕駛執照: \_\_\_\_\_

Email 電子郵件: \_\_\_\_\_

**Has Resident Made a Will 服務使用者是否已立遺囑?:**  Yes 是  No 否

Details of Person/Organization holding the Will 請填寫遺囑擁有人或機構資料:

Name 姓名/機構名稱: \_\_\_\_\_ Contact Number 聯絡電話: \_\_\_\_\_

Email 電子郵件: \_\_\_\_\_

<b>Applicant Name:</b>	<b>Name of POA/Medical Decision Maker /Representative: (if applicable)</b>
<b>Date:</b>	<b>Signature of applicant (or POA/Medical Decision Maker /Representative) :</b>