Casson Homes Incorporated

Est. 1922

Application for Admission

THANK YOU for considering Casson Homes Inc. to share your life journey. We appreciate the opportunity to explore your expectations about the care and services you are seeking and in partnership with you create a Lifestyle Support Plan that meets with your satisfaction.

We know moving into a residential facility is never an easy decision, nor one that you or your family may ever have thought you would have to make. So, again welcome to our home, and thank you for entrusting us to journey alongside you as we explore together your goals, wishes and aspirations for this next chapter of your life.

Firstly though, we would like to tell you a little about us and the services we provide. Casson Homes and Casson Communities specialise in caring for people living with medical or mental illness that is impacting their ability to live independently in the community. Casson Homes Inc embraces the organisation-wide philosophy of providing high quality care and individualised support with kindness and respect to people, to ensure they always feel valued, important, and safe living with us.

We have a robust policy on Diversity and Inclusion, recognising that *Diversity* is about what makes a person unique and includes their identity, life experiences, values and beliefs. We recognise that individuals are shaped by their personal characteristics, experiences, values and beliefs, and many people have specific social, cultural, linguistic, religious, spiritual, psychological affiliations and medical conditions.

Accordingly Casson Homes Inc is committed to

- engaging with you to understand your diverse characteristics, life experiences, interests and goals;
- empowering you to make informed decisions about the support you wish to receive to meet your goals and expectations; and
- effectively delivering flexible, accessible care services free of perceived or actual barriers and discrimination

Identifying and understanding your diverse needs, goals and expectations enables us to design and develop services that are relevant, culturally appropriate and safe for you. Together we believe we can create a collaborative and respectful partnership in the delivery of your care and support services.

Your accommodation preference

To assist our assessment process please indicate the type of accommodation you are seeking.

☐ Aged Care ☐ Supported Independent Living ☐ Hostel ☐ Transitional

Casson Homes Incorporated
5 Woodville Street
North Perth WA 6006
Phone: 9328 8422
Email: reception@cassonhomes.com.au

Section **A**

Please complete all sections to the best of your ability

Personal Information

First Name(s): _____ Surname: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Primary Language: _____ Country of Birth: _____ Interpreter Required?: ☐ Yes ☐ No

Identifies as: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefers not to say

Email: _____ Mobile: _____

Home Address: _____

☐ Own Home ☐ Rental ☐ Retirement Village ☐ Other: _____

Presently Living at: _____

Marital Status: ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Married ☐ Partner

We believe it is important that we only contact the people you want to be involved in your care when you move into our home. It is also important for you to let us know the people you do not want us to contact. Please let us know who you wish to be involved in the areas below:

Person you would like us to contact for <u>Medical</u> Decisions (e.g. should you become unwell)

☐ Self ☐ Enduring Power of Guardian (EPG) ☐ Guardian ☐ Next of Kin ☐ Other _____

Name: _____ Relationship: _____

Address: _____ Postcode: _____

Telephone: Home: _____ Mobile: _____

Email: _____

Person you would like us to contact for <u>Financial</u> Decisions (e.g. should you become unwell)

☐ Self ☐ Enduring Power of Attorney (EPA) ☐ Public Trustee ☐ Next of Kin ☐ Other _____

Name: _____ Relationship: _____

Address: _____ Postcode: _____

Telephone: Home: _____ Mobile: _____

Email: _____

Person you would like us to contact for <u>Lifestyle</u> Decisions (e.g. should you become unwell)

☐ Self ☐ Enduring Power of Attorney (EPA) ☐ Public Trustee ☐ Next of Kin ☐ Other _____

Name: _____ Relationship: _____

Address: _____ Postcode: _____

Telephone: Home: _____ Mobile: _____

Email: _____

People (friends or family members) you do not want us to speak to :

_____

Social Worker (if appropriate)

Name: _____

Hospital: _____

Mobile: _____

Email: _____

Referral Agency (if appropriate)

Name: _____

Case Manager: _____

Mobile: _____

Email: _____

General Practitioner

Name: _____

Practice: _____

Address: _____

_____ Phone: _____

Other Agencies

_____

_____

_____

_____

Section B

Please complete all sections to the best of your ability

Pension, Medicare, and Insurance Information

Pension Number: ☐☐☐☐☐☐☐☐☐☐ Expiry Date: ____/____

Type: ☐ Full ☐ Part ☐ DVA ☐ White ☐ Gold

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

☐ Number on Medicare card in front of your name Expiry Date: ____/____

Private Health Fund: _____ Membership Number: _____

Ambulance Fund: _____ Membership Number: _____

Section C

Please complete with the person, or on behalf of the person requiring services from us.

This information will assist us to create a care support plan that meets their/your expectations, goals and preferences for care.

About Me

We offer diverse and inclusive services and in order for us to better understand your goals and preferences for care and services we invite you to reflect on the following questions, and where you are comfortable, provide us with some information about yourself. Do you identify with any of the following groups ?

☐ People from Aboriginal and Torres Strait Islander Communities.

☐ People from Culturally and Linguistically Diverse backgrounds (CALD).

☐ People who live in rural and remote areas.

☐ People who are financially or socially disadvantaged.

☐ People who are homeless or at risk of becoming

☐ Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) people.

☐ Parents separated from their children by forced Adoption or removal.

☐ Care Leavers

☐ People Living with Dementia

☐ People living with mental illness.

Tell us about your current health concerns and how this is impacting on your daily life and your ability to stay where you are currently living: _____

_____

Tell us what you currently hold dear and is important for you to continue _____

_____

How often do you visit your GP? _____

Will you current GP continue to care for you in our home? ☐ Yes ☐ No

If 'No', will your GP provide us with a current health summary of your past medical/mental health concerns and surgical procedures? ☐ Yes ☐ No

If 'Yes' we need you to ring your GP and request release of this information to us at the earliest opportunity.

What is the best way we can provide information to you to assist your understanding of the Services we can provide? For example:

Would you like us to organize an interpreter: ☐ Yes ☐ No
Would you like us to organize visual aids – such as large print brochures ?
Do you require any assistance with... Vision ☐ Yes ☐ No Hearing ☐ Yes ☐ No

Do you have any other suggestions how we may be able to assist you?

_____

Mental Health History

Is there a Community Treatment Order in place: ☐ Yes ☐ No

Current diagnosis: _____

Present stability of mental state: _____

Current suicide risk: _____

Approximate date of onset: _____ Number of Admissions: _____

Date of most recent admission: _____ Duration and Severity: _____

Family mental health history: _____

_____

_____

Risk Issues

History of alcohol or other substance abuse	☐ Yes	☐ No	History of self harm	☐ Yes	☐ No
History/Risk of harm to others	☐ Yes	☐ No	Risk of harm from others	☐ Yes	☐ No
Forensic history	☐ Yes	☐ No	History of antisocial/aggressive behaviour	☐ Yes	☐ No
History of sexual vulnerability	☐ Yes	☐ No	Pending Legal proceedings	☐ Yes	☐ No
Are you a smoker	☐ Yes	☐ No	How many cigarettes per day? _____		

Fire Risk ☐ Yes ☐ No

If Yes, please comment _____

_____

Medication Management

Independent with taking own medication ☐ Yes ☐ No
Needs supervision ☐ Yes ☐ No
Needs full assistance ☐ Yes ☐ No
Needs medication to be crushed ☐ Yes ☐ No
Resistant/refuses to take medication ☐ Yes ☐ No
Is on daily injections _____ ☐ Yes ☐ No
Is on periodic injections _____ ☐ Yes ☐ No
Other (specify) _____

Medical History

What vaccinations have you had?: Fluvax ☐ Yes ☐ No Pneumovax ☐ Yes ☐ No Covid-19 ☐ Yes ☐ No
Other (specify) _____
Please list any allergies or drug intolerance: _____
_____
What is your current weight : _____ How tall are you?: _____

Mobility

☐ Full mobility
☐ Walks with aids (cane, frame)
☐ Uses a wheelchair
☐ Bedridden
☐ Independent but very slow
☐ Needs supervision
☐ Needs assistance
☐ Other (specify) _____
Comments: _____
_____

Falls Risk

What is your history of past falls/injuries: _____
_____
Frequency of Falls: _____
Comments: _____
_____

Cognition and behaviours

☐ Short term memory problems
☐ Long term memory problems
☐ Verbal aggressive behaviours
☐ Physical aggressive behaviours
☐ Confusion
☐ Disorientation
☐ Wandering
☐ Other (specify) _____
Comments: _____
_____

Continence

Continent (faecal and urinary) ☐ Yes ☐ No Require Pads ☐ Yes ☐ No
If yes, who is responsible for paying for pads and will this arrangement continue? _____
_____

Activities of Daily Living

If you cannot perform the following activities independently, please advise level of assistance required.

Meals and drinks: _____

Showering/washing: _____

Grooming: _____

Brushing Teeth: _____

Toileting: _____

Cleaning of personal living space: _____

_____

Accommodation History

Independent community ☐ Yes ☐ No _____

Supported Living ☐ Yes ☐ No _____

Hostel ☐ Yes ☐ No _____

Aged Care Facility ☐ Yes ☐ No Date of Entry: _____

Reason for leaving previous accommodation : _____

_____

Reason for hostel placement: _____

Social History

What social activities do you enjoy and would like to continue? _____

_____

_____

Have you thought about who might be able to assist you to continue these social activities whilst living with us? ____

_____

Have you thought about what you would like us to do to assist you to continue to access your preferred social activities? _____

Would you like us to be aware of any other personal, cultural or spiritual connections? _____

_____

Is there anything else you would like us to know about your life, past experiences or your family? _____

_____

Aged Care Assessment (if applicable)

An Aged Care Assessment (ACAT) can also be called an Aged Care Client Record (ACCR) or a Support Plan.

Do you have an ACAT assessment? ☐ Yes ☐ No Date of assessment: ____/____/____

If Yes, please attach a copy of the assessment to this application.

If you don't have a copy, please provide the referral code for Permanent Residential Care approval.

Referral code number: ☐ - ☐☐☐☐☐☐☐☐☐☐

Section **D**

Please complete all sections to assist us to determine your financial status so we can provide you with your costs when entering Aged Care

Income and Assets (Aged Care Applicants only)

Income (per annum)

Australian Government Pension	$
Overseas Pension	$
Superannuation Income Stream	$
Other Income	$
Total Income per annum	$

Financial Assets

Principle Home (estimated market value)	$
Cash at Bank	$
Term Deposits, Bonds	$
Shares	$
Gifting Assets	$
Total amount	$

Other Assets

Superannuation Balance	$
Investment/additional properties	$
Other Assets _____	$
Total Amount	$

Debts

Loan, mortgage, or encumbrance	$

Notes

Section **F**

Please complete all sections to assist us to determine your financial status so we can provide you with your costs when entering Aged Care

Disclaimer/Declaration

☐ By checking this box, I sincerely declare that all of the information in this application is true to the best of my knowledge. It is in no way false, inaccurate or misleading, or intended to be false, inaccurate of misleading. I agree that if incorrect fees or charges are levied as a result of information provided in this application, then Casson Homes Inc may levy the correct charges from the Applicant's date of entry to a Casson Homes Inc. facility.

This application was completed by: ☐ Applicant ☐ Applicant's Representative

I declare the information contained in this aspplication is to my knowledge true and correct.

Name: _____ Date: _____/____/_____

Relationship to Applicant: _____ Signature: _____

Application Checklist

To assist with the timely processing of your application please ensure that all sections are completed and you have provided the following documents with this application.

☐ Copies of Power of Attorney and/or Guardianship approvals (if applicable)

☐ A copy of your Aged Care Assessment or referral code (Aged Care applicants only)

☐ A copy of Centrelink Aged Care Fees Letter

If you have any difficulty or concerns in answering any of the sections or have any queries do not hesitate to phone us on

9328 8422

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