



Yallambee

Traralgon Village for the Aged Inc.

Live at Ease.

Application for Yallambee Village



Yallambee Traralgon Village for the Aged Inc.
Matthews Crescent, Traralgon Vic 3844
(p) (03) 5132 3500
(e) info@yallambee.com.au



Applicant Details

Here we ask for the usual contact information plus a few more questions so that we can get to know some more about you.

Applicant one details:

Please write your name exactly as it appears on your Medicare or Pensioner Concession Card.

Title (Mr, Mrs, Miss etc): _____

First name(s): _____

Preferred name: _____

Last name: _____

Address: Street: _____

Suburb: _____ State: _____

Contact information: Home: () _____ Postcode: _____

Mobile: _____

Email: _____

Date of birth: _____

Applicant two details if applicable:

Title (Mr, Mrs, Miss etc): _____

First name(s): _____

Preferred name: _____

Last name: _____

Date of birth: _____

Marital Status _____ Country of Birth: _____

Cultural Background _____ Religion (optional) _____

Are you of Aboriginal or Torres Strait Islander origin?: No Yes, Aboriginal

Yes, Torres Strait Islander

Do you require an interpreter for everyday English? No Yes

Is there anything in particular you would like us to know about your religion or spiritual needs, or cultural background? If yes, please provide details below.



Primary Contact

If you are completing this form on behalf of the applicant, please provide your details below.

Title (Mr, Mrs, Miss etc): _____
First name(s): _____
Preferred name: _____
Last name: _____
Relationship to applicant: _____
Address: Street: _____
Suburb: _____ State: _____
Contact information: Home: () _____ Postcode: _____
Mobile: _____
Email: _____

Do you have the legal authority to make decisions on the applicant's behalf?

Yes No

If yes, what type of authority do you have?

Enduring Power of Attorney Enduring Power of Guardianship Administrator

Other, please advise: _____

Reason for Application

Where did you hear about us?

Word of mouth Website Open day

Newspaper Facebook Event

Other

When do you require accommodation?

As soon as possible Future date (please advise) Date ____/____/____

What type of accommodation would you like to apply for?

1 - bedroom 2 - bedroom 2- bedroom Villa

Are you looking to rent or purchase?

Rent Purchase



Health Membership Details

Pension details:

Please indicate whether you have a pension:

Full pension Part pension I do not receive a pension

If you receive a pension, please indicate the type:

Age Disability Widow DVA Blind

Please enter your pension concession number (if applicable):

Expiry date: /

Enter your DVA treatment card number (if applicable):

Expiry date: / Colour (please tick): Gold White Orange

Medicare details:

Please enter your Medicare card number:

 - -

Individual reference number Valid to: /

Health fund details:

If you have private health insurance, please provide the following details:

Your health fund provider name: _____

Your membership number:

Expiry date: /

Ambulance cover details:

If you have ambulance cover, please provide the following details:

Your ambulance cover provider name: _____

Your membership number:

Expiry date: /

Your Assets

Do you presently own your own home?

Yes No

Or

Do you presently rent a home?

Yes No

Or

Do you presently live with family?

Yes No

Rental References

Please provide details of two rental references

Referee one

Title (Mr, Mrs, Miss etc):

First name(s):

Last name:

Contact information:

Home: ()

Mobile:

Email:

Relationship to applicant:

Referee two

Title (Mr, Mrs, Miss etc):

First name(s):

Last name:

Contact information:

Home: ()

Mobile:

Email:

Relationship to applicant:



Your Medical Contacts

It's important for us to know who your doctor is and details of anyone else who is important to your ongoing medical treatment or healthcare.

Your general practitioner

Name of your GP: _____

Name of your GP's medical practice (if applicable): _____

Address: Street: _____

Suburb: _____

State: _____

Postcode: _____

Contact: Telephone: () _____

Email: _____

Please indicate if you intend to continue to use your GP if you are offered a place at Margery Cole:

Yes No Unsure

Pharmacy Details

Name: _____

Address: _____

Contact: Telephone: () _____

Email: _____

Other health professionals important to your care

Name: _____

Field/speciality: _____

Contact: Telephone: () _____

Email: _____

Name: _____

Field/speciality: _____

Contact: Telephone: () _____

Email: _____

Please attach a separate sheet if there is insufficient space.

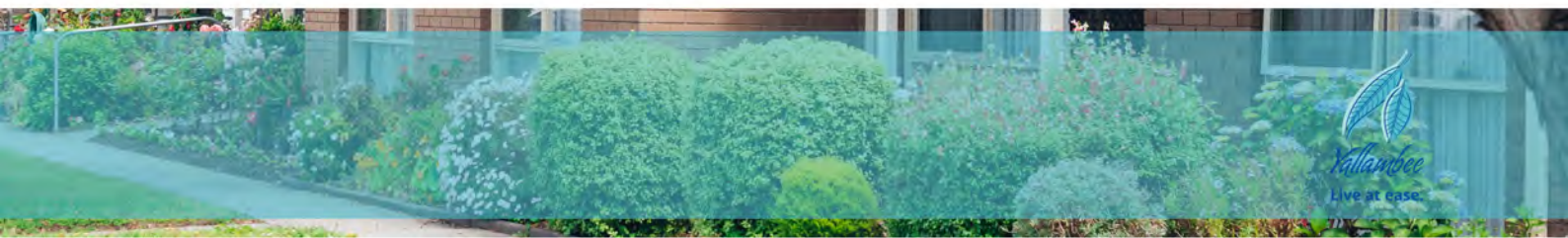


Final Note

Please read before submitting:

- Please do not sign this form before making a copy, original signatures are required on the original and a copy for your own records. Margery Cole Reception staff will happily photocopy this document for you if you require it.
- Attach a copy of your Income and Assets Statement
- Attach a copy of your Rental references.
- Attach a copy of the relevant authority, such as a Power of Attorney, if someone else has the legal power to make decisions on your behalf OR if an authorised representative is signing this application on your behalf.

Your application WILL NOT BE FINALISED without the supporting information mentioned above.





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