AGED CARE CLIENT RECORD [APPLICATION FORM]

Client Identification Number

Name of ACAT Team

Name of the ACAT Assessor

Assessor Signature

PRIVACY NOTICE

The Aged Care Assessment Team (ACAT) is collecting the information on this form to work out if you are eligible to receive aged care or other community, health or social services. This is authorised by the *Aged Care Act 1997*.

The ACAT usually gives some or all of this information to:

- the Department of Health and Ageing
- the Department of Veterans' Affairs (if applicable)
- the Department of Human Services
- relevant State or Territory agencies
- appropriate medical and nursing staff
- relevant service providers

The ACAT also uses the information to report on, and conduct research into, the level of need for aged or other community, health or social services.

The Department of Health and Ageing sometimes gives the information it receives from the ACAT to other people or agencies if this is permitted by the *Aged Care Act 1997*.

APPLICATION FOR APPROVAL

Complete this part of the form if you are applying for approval to receive aged care under the *Aged Care Act 1997*.

Print your name (exactly as it appears on your Medicare card or DVA concession card).

I am applying for approval to receive the type(s) of aged care I have ticked below. (Tick at least one box).

Residential care ☐ Home Care Package ☐

Residential respite care ☐ Flexible care ☐

Note that if the ACAT decides that you are eligible to receive a type of aged care, this does not mean that you must agree to receive that type of care.

I authorise the use and disclosure of my personal information in the ways described in the Privacy Notice above.

Signature Date: __/__/____ (DD/MM/YYYY)

This form should be signed by the applicant. Only in exceptional circumstances should someone else sign. If this is the case, please COMPLETE the following.

- Why was the applicant unable to sign?
- Name of person who did sign (please print)
- Relationship to the applicant (eg Guardian, Power of Attorney, Spouse, GP, Solicitor, etc)
- Contact details: Address and telephone number

Unit No./No. Street:

Suburb:

Postcode: State/Territory: Telephone: ( )

To be completed by the service provider in EMERGENCY CASES ONLY

EMERGENCY The person urgently needed the care when it started and it was not practicable to apply for approval beforehand. Yes ☐

If YES, reasons for emergency approval must be included in the Rationale for Care Recommendation in Q42.

Service Provider Number

Signature

Date care started __/__/____ (DD/MM/YYYY)