



**Braemar Presbyterian Care**  
PO Box 1115, Willagee WA 6156  
Phone: (08) 6279 3640  
admissions@braemar.org.au  
www.braemar.org.au

# Application for Residential Accommodation

The resident or their carer should complete this form. Please ensure all details are complete and accurate to the best of your knowledge.

**Full name of applicant:**

**Date of application:**

**Type of care being sought:**

Respite Care

Permanent Residential Care

**Preferred Facility:**

**Braemar Coinda**  
31 Moorhouse Street  
Willagee WA 6156

**Braemar House**  
10 Windsor Road  
East Fremantle WA 6158

**Braemar Village**  
24-32 Charsley Street  
Willagee WA 6156

## Aged Care Information

**Please note:** We are unable to process applications for Permanent Residential Care without a current copy of both the Combined Assets and Income Assessment (SA457) from Centrelink and the applicant's ACCR or Support Plan. To process applications for Respite Care, we require a current ACCR or Support Plan approved for respite care.

Has the ACAT completed an ACCR or Support Plan?  Yes  No

Date of Assessment:  
*(Please enclose a copy with your application)*

Has Centrelink completed a Combined Assets and Income Assessment?  Yes  No

Date of Assessment:  
*(Please enclose a copy with your application)*

## Applicant Details

*(Please write your name exactly as shown on your Pensioner Concession Card, if applicable)*

Title:  Mr  Mrs  Miss  Dr  Other (please specify):

Family name: Gender:  Male  Female

Given name/s: Date of birth:

Preferred name: Marital status:

Home telephone: Mobile:

Home address:

Street:

Suburb: Post code:

Present address (if different from above):

Street:

Suburb: Post code:

## Have you accessed any of the following services in the current financial year?

*If yes, please check:*

Residential Respite Care

In Home Respite

Permanent Residential Aged Care

Home Care Package

Please provide details:

Name of Service Provider	Type of Service	Dates
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

## Pension Details

Pension type:  Full pension  Part pension  No pension

Pension number:

DVA gold card:  Yes  No

Card number:

Medicare number:

Expiry date:

Do you have private health care:  Yes  No

Name of fund:

Member number:

Level of cover:

Ambulance cover:  Yes  No

Row number:

Expiry date:

## Cultural Information

Aboriginal/Torres Strait Islander:  Yes  No

Nationality:

Country of birth:

Language spoken:

Interpreter required:  Yes  No

Faith/Religious denomination:

## Spouse/Partner information (if applicable)

Title:  Mr  Mrs  Miss  Dr  Other (please specify):

Family name:

Given name/s:

Date of birth:

Preferred name:

Marital status:

Home address:

Street:

Suburb:

Post code:

## Next of Kin Details

Please provide details of a nominated representative Braemar can contact, if required, in relation to your care after you enter our service. Residents often have a number of family members who can be classed as their Next of Kin. It is essential that you make clear who the Primary Contact will be and provide details of when and how they should be contacted.

Braemar staff only communicate with one family member or carer, the expectation is that the family member or carer will then manage communication between all others.

**Please Note:** The Power of Attorney (POA) only has power regarding financial and legal decisions, but not healthcare, lifestyle or accommodation. The Guardian only has power regarding healthcare, lifestyle and accommodation decisions, but not financial and legal decisions. A single person may hold both types of authority.

## Primary Contact

Name:

Relationship:

Home address:

Postal address (if different from above):

Home telephone:

Work telephone:

Mobile:

Email:

**Power of Attorney:**  Yes  No  
*(if yes, please enclose a copy with your application)*

**Guardianship:**  Yes  No  
*(if yes, please enclose a copy with your application)*

## Secondary Contact *(will only be contacted in the event that the Primary Contact is unreachable)*

Name:

Relationship:

Home address:

Postal address (if different from above):

Home telephone:

Work telephone:

Mobile:

Email:

**Power of Attorney:**  Yes  No  
*(if yes, please enclose a copy with your application)*

**Guardianship:**  Yes  No  
*(if yes, please enclose a copy with your application)*

## Billing Information

Name: Relationship:  
Billing address:  
Home telephone: Work telephone:  
Mobile: Email:

Will the applicant also be receiving billing information?  Yes  No

## Resident and Representative Newsletter

Please indicate an email address if you wish to receive our monthly communication:

Email:

## Signature of Applicant or Representative

Please ensure all details are complete and that the information is accurate to the best of your knowledge.

Name of person signing application:

Signature: Date:

Please retain a copy of this application for your records and return the original along with the following supporting documents to:

Braemar Presbyterian Care | PO Box 1115, Willagee WA 6156 | [admissions@braemar.org.au](mailto:admissions@braemar.org.au)

- Aged Care Client Record (ACCR) or Support Plan
- Centrelink Combined Income and Asset Assessment
- Power Of Attorney (POA) (if applicable)
- Guardianship (if applicable)