

APPLICATION FOR TERRACE INDEPENDENT LIVING

Name:		Preferred Name:	
Current Address:			Postcode:
Phone No:		Mobile No:	
Email address:			
Date of Birth: / /		Country of Birth:	
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other			
Religion:			
Name of Medical Officer:		Phone No:	
Address: (Please provide a health summary information sheet from your Medical Officer)			
Medicare No:		Expiry date:	
Private Health fund: ☐ Yes ☐ No		Membership No: Expiry date:	
Name of Fund:			
Pension Received? ☐ Yes ☐ No Expiry date: ☐ Age ☐ DVA ☐ Disability			
Pension No: ☐ Part Pension ☐ Full Pension Expiry date:			
Has an ACCR Assessment been carried out? (ACAT) ☐ Yes ☐ No (If yes, please attach copy) Date ACCR was completed / /			
Do you have an Advance Care Directive or Plan?: ☐ Yes ☐ No Is a copy accessible? ☐ Yes ☐ No (please provide a copy)			
Second Person's Name :		Preferred Name:	
Current Address:			Postcode:
Date of Birth: / /		Country of Birth:	
Religion:			
Name of Medical Officer:		Phone No:	
Address: (Please provide a health summary information sheet from your Medical Officer)			
Medicare No:		Expiry date:	

Private Health fund: ☐ Yes ☐ No		Membership No:
Name of Fund:		
Pension Received? ☐ Yes ☐ No		Expiry date: ☐ Age ☐ DVA ☐ Disability
Pension No:		☐ Part Pension ☐ Full Pension
Has an ACCR Assessment been carried out? (ACAT) ☐ Yes ☐ No (If yes, please attach copy)		
Date ACCR was completed / /		
Do you have an Advance Care Directive or Plan?: ☐ Yes ☐ No Is a copy accessible? : ☐ Yes ☐ No (please provide a copy)		
Nominated Representative (Primary Contact):		
Relationship:	POA ☐ Yes ☐ No Enduring Guardianship ☐ Yes ☐ No	
Address:		
Home Phone No:	Mobile:	
Email:		
Next of Kin (Secondary Contact):		
Relationship:	POA ☐ Yes ☐ No Enduring Guardianship ☐ Yes ☐ No	
Address:		
Home Phone No:	Mobile:	
Email:		
How would you like to receive communication from Maroba? ☐ Email ☐ Hardcopy/Mailbox		
Name:	Signature:	Date:
Name:	Signature:	Date: