

IMPORTANT

Before entering into a Rooming Agreement, you have a duty to inform us of everything you know that may affect Skymac Groups' decision to enter into an agreement.

Completing this form allows Skymac to assess whether we can provide the appropriate support to assist you in your everyday life. Skymac may hold you accountable should incorrect information be provided. Refer Conditions of Entry – Collection Notice for further details.

Should you need any assistance completing the application, please don't hesitate to contact our office.

CLIENT INFORMATION (Form-0001A)

PERSONAL INFORMATION

Last Name:

First Name:

Preferred Name:

Date of Birth:

Mobile:

Age:

Do you identify as Aboriginal or Torres Strait Islander?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Prefer not to specify
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Hobbies

Gender:

<input type="checkbox"/>	Female	<input type="checkbox"/>	Male	<input type="checkbox"/>	Other:
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Likes:

Dislikes:

NEXT OF KIN

Name:

Relationship:

Phone Number:

Email:

Second Contact Name and Relationship:

Best Contact (email or phone number):

POWER OF ATTORNEY or GUARDIAN or ADMINISTRATOR (Please attach evidence)

Name:

Relationship:

Phone Number:

Copy of Power Attorney attached:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Full power and authority for:

<input type="checkbox"/>	Medical/personal	<input type="checkbox"/>	Financial	<input type="checkbox"/>	Other (please specify):
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NDIS

Do you have a NDIS Plan?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If YES, please complete the following:

NDIS Plan Number:		Plan Dates:	
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Is your plan:

<input type="checkbox"/> NDIS (Agency) Managed	<input type="checkbox"/> Self-Managed	<input type="checkbox"/> Plan Managed
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If Plan Managed:

Plan Manager:

Email:

Phone:

Do you have a NDIS Support Coordinator?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If YES, who is your coordinator?

Name:

Email:

Phone:

HEALTH CARE / PENSION / PUBLIC TRUST INFORMATION

Pension/Centrelink Number:

Expiry Date:

Medicare Number:

Expiry Date:

Private Health Care:

Health Card Number:

Public Trust Reference Number (PTQ):

MEDICAL CONTACTS

General Practitioner:

Email:

Address:

Phone:

Psychiatrist:

Phone:

Email:

Treating Hospital:

Phone:

Social Worker:

Phone:

Email:

Clinical Nurse:

Phone:

Email:

Community Support (if required):

Phone:

Authority to contact medical professionals authorised by:

Name:

Phone Number:

Signed:

Date:

Witness:

Date:

MEDICAL INFORMATION

Have you had the most recent flu vaccination?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If YES, please provide the date (if known):

Have you had a COVID-19 vaccination?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If YES, please provide the dates of the first and second dose (if known):

First Dose	<input type="text"/>	Second Dose	<input type="text"/>
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General Medical Information:

Known Allergies:

It is the client's responsibility to disclose to us their known allergies, and to confirm for themselves whether meals are free of allergens. We accept no responsibility for illness or injury caused by allergic reaction experienced due to a client's negligence, nor if a client does not disclose to us their known allergies.

Special Dietary Requirements* Please refer to our Fees & Charges if filling in this section):

PRIMARY DISABILITY

<input type="checkbox"/>	Acquired Brain Injury	<input type="checkbox"/>	Sensory/Speech
<input type="checkbox"/>	Autism	<input type="checkbox"/>	Spinal Cord Injury
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	Visual Impairment
<input type="checkbox"/>	Intellectual Disability	<input type="checkbox"/>	Other Neurological:
<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Other Physical:
<input type="checkbox"/>	Psychosocial Disability	<input type="checkbox"/>	Other:

MOBILITY

<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	Walker	<input type="checkbox"/>	Walking Stick	<input type="checkbox"/>	Independent
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FAMILY, SOCIAL AND CULTURAL SITUATION

i.e., Children, parents, carers, can they speak English, married, single.

COMMUNICATION, SUPPORT AND PHYSICAL NEEDS

***Please note, this is for assessment of suitability only to give an initial indication of the applicant's health and care needs. The following services are available for an additional fee over and above the cost of standard Board and Lodging.**

Does the applicant have any behaviours of concern?

<input type="checkbox"/>	Food-related	<input type="checkbox"/>	Unintentional self-risk
<input type="checkbox"/>	Eating non-food items	<input type="checkbox"/>	Leaving premises without support
<input type="checkbox"/>	Property damage	<input type="checkbox"/>	Refusal to do things
<input type="checkbox"/>	Physical aggression	<input type="checkbox"/>	Repetitive or unusual habits
<input type="checkbox"/>	Verbal aggression	<input type="checkbox"/>	Offending behaviour
<input type="checkbox"/>	Harm to self	<input type="checkbox"/>	Sexually inappropriate behaviour
<input type="checkbox"/>	Other:		

Does the applicant require any of the following?

If yes, please indicate if a Management Plan is in place and attach a copy.

Tick if required	Support type	Comments	Management Plan Attached: Yes/No/N/A
<input type="checkbox"/>	Shower assistance		
<input type="checkbox"/>	Toilet assistance		
<input type="checkbox"/>	Mealtime Management		
<input type="checkbox"/>	Epilepsy Management		
<input type="checkbox"/>	Incontinence/stoma assistance		
<input type="checkbox"/>	Diabetes Management		
<input type="checkbox"/>	Medication assistance		
<input type="checkbox"/>	Additional laundry		
<input type="checkbox"/>	Additional room cleaning		
<input type="checkbox"/>	Financial assistance		
<input type="checkbox"/>	Accessing the community		
<input type="checkbox"/>	Tobacco management		
<input type="checkbox"/>	Positive Behaviour Support		
<input type="checkbox"/>	Asthma Management		
<input type="checkbox"/>	Other:		

PERSONAL HISTORY (including behavioural issues):

How does the applicant normally communicate?

Please select appropriate box.

SPEECH	<input type="checkbox"/>	Verbal communication	<input type="checkbox"/>	Adjusted verbal communication	<input type="checkbox"/>	Electronic communication	<input type="checkbox"/>	Picture communication
	<input type="checkbox"/>	Sign language	<input type="checkbox"/>	Other signing	<input type="checkbox"/>	Use of gestures	<input type="checkbox"/>	Interpreter

Does the person require informal decision-making support?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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HEARING	<input type="checkbox"/>	No loss	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	Communication aid
	<input type="checkbox"/>	Requires assistance to maintain aids		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EYESIGHT	<input type="checkbox"/>	Good	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Failing	<input type="checkbox"/>	Blind
	<input type="checkbox"/>	Requires assistance to maintain aids		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RECOGNITION	<input type="checkbox"/>	Family	<input type="checkbox"/>	Friends	<input type="checkbox"/>	Unresponsive
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CRIMINAL HISTORY

Criminal History:

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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If YES, please provide further information:

DRUGS AND ALCOHOL

Do you use any of the following?

Nicotine (e.g., cigarettes, tobacco)		Yes		No
Alcohol (including methylated spirits)		Yes		No
Amphetamines (e.g., speed, goey, ice)		Yes		No
Opioids (e.g., methadone, heroin, morphine)		Yes		No
Benzodiazepines (e.g., Temazepam, Diazepam)		Yes		No
Designer drugs (e.g., MDA, ecstasy, MDMA designer drugs)		Yes		No
Inhalants (e.g., glue, petrol, paint, others)		Yes		No
Others (e.g., pain killers, over the counter medications)		Yes		No

RISK OF HARM

Suicide	
I.e., Attempts, thoughts, isolation, self-harm (ask for dates).	
Comments:	
Violence	Absconding
Verbal abuse	Current legal matters
Criminal history	Sexual violence
Vulnerability	Physical aggression

Known issues relevant to behaviour (i.e., behaviour/reaction to alcohol):

Are you willing to address your substance use?

Yes	No
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Are you linked with a drug and alcohol support service (i.e., AA, NA)?

Yes	No
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MONEY MANAGEMENT AND INCOME

Income Type:

Next Pay Day:

Who will be paying the rent?

<input type="checkbox"/>	Centrelink	<input type="checkbox"/>	Public Trust
<input type="checkbox"/>	Family	<input type="checkbox"/>	Self-managed

Centrelink Card Number:

<input type="checkbox"/>	Do you require assistance with your Centrelink application?

TRANSPORTATION

Tick the boxes below if you have any of the following cards:

<input type="checkbox"/>	Companion Card	<input type="checkbox"/>	Taxi Subsidy Card	<input type="checkbox"/>	Translink Access Card
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REFERRAL INFORMATION

Referring Agency and Name:

Email:

Phone:

Where did you hear about us?

<input type="checkbox"/>	Facebook	<input type="checkbox"/>	Search Engine	<input type="checkbox"/>	Word of mouth	<input type="checkbox"/>	Other:
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ACCOMMODATION TENANCY HISTORY

Have you lived in supported accommodation before?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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If YES, where?

Accommodation Name:	<input type="text"/>	Phone:	<input type="text"/>
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Can we telephone the last accommodation provider for a reference?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been evicted by any Lessor or Agent?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you in debt to another Lessor or Agent?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is there any reason known to you that would affect your ability to pay rent when due?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
History of homelessness?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Other comments:				
<input type="text"/>				

ACKNOWLEDGEMENT AND CONSENT BY APPLICANT

Applicant Name:

Guardian Name:

Signature:

Signature:

Date:

Date:

FOR OFFICE USE ONLY

Assessor's Name:

Date of Referral:

Place offered (yes or no):

Date placement pack sent:

Date of Arrival:

Date of Departure:

CONDITIONS OF ENTRY

TERMS OF RESIDENCY

1. Fees are required to be paid two weeks in advance.
2. Applicants will not take up occupancy until all fees and charges are paid.
3. Fees will be adjusted in line with full single pensioner payment including rental assistance, Centrelink increases etc.
4. One week's notice, or one week's fees in lieu of notice, must be given if a resident wishes to vacate the facility.
5. In the case of extended hospitalisation, the fees may be reduced on application after four weeks in hospital.
6. The resident is responsible for all costs associated with transfer to and from a hospital.
7. A key replacement fee of \$50.00 will apply to lost or stolen keys.
8. Residents are responsible for providing special food items i.e., gluten free bread, soy milk or Halal meat etc. at their own costs. This must be discussed at time of interview.
9. Applicants/residents are to adhere to the Policy and Procedures of the facility, deviation from this may result in a Breach Notice or Notice to Terminate.
10. Management reserves the right not to accept a referral.
11. Skymac Pty Ltd and Australian Quality Care Pty Ltd adheres to the Residential Services Accommodation Act 2002.

PRIVACY DISCLOSURE STATEMENT

We are an independently owned and operated business and are bound by the National Privacy principles. We collect personal information about you in this form to assess your Application for Tenancy. We may need to collect information about you from your previous Lessors or Letting Agents, your Employer and Referees. We will also check if details of Tenancy defaults by you are held on a Tenancy Database. Your consent for us to collect the information is set out below in the Privacy Consent section.

COLLECTION NOTICE

The personal information you provide in this Application or the information we collect from other sources is necessary to verify your identity, to process and evaluate the Application and to manage the Tenancy. If the Application is successful, personal information collected about you in this Application and during the course of your Tenancy, may be disclosed for the purpose for which it was collected to other parties including the Lessor, Referees, other Agents and third-party operators of Tenancy Databases. If you enter into a General Tenancy Agreement and if you fail to comply with your obligations under the Agreement, the facts and other relevant personal information collected about you during the course of your Tenancy may also be disclosed to the Lessor, third party operators of Tenancy Databases and/or other Agents.

You have the right to access personal information that we hold about you by contacting our Privacy Officer. You can also correct this information if it is inaccurate, incomplete, or out of date. If your Application is not successful it will be stored securely for a period of one month only. If you decide not to collect your application, we will destroy your documents to comply with Privacy Legislations.

If you do not complete this form or you do not sign the consent form below, the Application for Tenancy may not be considered by the owner of the relevant Property or, if considered, may be rejected, due to insufficient information to assess the Application.

CHANGING THIS AGREEMENT

Please let us know if you would like to discuss any changes to this agreement. If we agree that we can support these changes, a new agreement will be drafted for you to sign and return to us. If you want to end this agreement, you agree to give us 30 days' notice. If we seek to end this agreement, we agree to give you 30 days' notice. If either you or Skymac Pty Ltd seriously breaches this agreement, no period of notice will be required to end this agreement.

By signing below, you acknowledge that you understand and agree to the terms and conditions listed in this document.

PRIVACY CONSENT

I acknowledge that I have read the above Privacy Disclosure Statement and Collection Notice. I authorise Skymac Pty Ltd and Australian Quality Care Pty Ltd to collect information about me from:

- My previous letting Agents and/or Lessor
- My personal referees, employers and all other references on this application

I authorise Skymac Pty Ltd and Australian Quality Care Pty Ltd to refer my name and contact details to an arranger or service provider including tradespeople (to attend to work required at the Property), salespeople (primary and secondary Agents), valuers, other Agents, database operators.