

60 Weldon Street Burwood NSW 2134

(02) 8741 0218 T

(02) 9747 1637 F

info@anhf.org.au E www.anhf.org.au

Application for Admission (Residential Care) 入住療養院申請

Applicant's Last Name:	First Name:
申請人中文姓名:	
FOR OFFICE USE Date form received:	Ref No:
In order to help us to review your applic meet your personal needs, please do the	
Complete this application form (RComplete Nomination of Authoritsubmit both forms together with r	y & Contact Details form (RS6009) and
為了幫助我們審查您的申請,並確定我請按照以下步驟:	們的療養院服務能滿足您的個人需求,
□填寫此申請表格(RS6005) □填寫提名授權和聯繫方式表格(RS60 □連同相關支持文件一起提交。	009),

A guide to completing your application 完成申請的指南

How do I submit my application?

Please sent your completed application to 60 Weldon Street, Burwood NSW 2134 or email to applications@anhf.org.au

What happens next?

We will contact you to acknowledge receipt of your application. Our team will call you to discuss your application. If the nursing home you selected is able to meet your needs but does not have an appropriate bed available, we will place your application on a waiting list. Please do not hesitate to contact us on (02) 9784 0863 if you have any questions.

如何提交申請?

完成申請表後,請交回 60 Weldon Street, Burwood NSW 2134
 或發送電子郵件至 applications@anhf.org.au

接下來發生什麼?

- 我們將與您聯繫以確認收到您的申請。
- 我們的團隊會打電話給您討論您的申請。
- 如果您選擇的療養院能夠滿足您的需求,但該沒有合適的床位,您的申請將被列入候補名單。
- 如果您有任何問題,請隨時與我們聯繫: (02) 9784 0863 或發送電子郵件至 applications@anhf.org.au



Application Date: 申請日期:	

Part A Which facilities are you interested in?
您對哪間療養院感興趣?
1.Bernard Chan Nursing Home 陳秉達療養院 (Burwood) □
2.Chow Cho-Poon Nursing Home 周藻泮療養院(Earlwood) □
3. Huang Ying Jung Nursing Home 黃應榮療養院(Gordon) □
4. Lucy Chieng Aged Care Centre 錢梁秀容療養院(Hurstville) □
Please list all nursing homes in order of preference of your choice, e.g. 3,1, 2
請按您選擇的優先順序列出所有療養院,例如 3,1,2,4

Part B: About applicant: your personal information 關於申請人: 您的個人信息				
Mr 先生 □Mrs 太太 □ N	//s 女士 □	Gender 性別	刂 Male 男 □ Fe	male 女 □
Family Name 姓	First Names 名		Chinese Name 中文姓名	
Date of Birth 出生日期		Religion 宗教		
Place of Birth 出生地點		Language 語言		
Address 地址				
Suburb 地區		Postcode 郵	區編碼	
Home Phone 家居電話		Mobile Pho	ne 手提電話	
Email 電郵地址				
Referred by 介紹人				

Name of Person Responsible for Care 護理負責人	Relationship of the Person Responsible for Care to the Applicant
Last Name:	護理負責人與申請人的關係
Last Name.	│ │ □ Father 父親 □Mother 母親 □ Husband 丈夫
First Name:	│ □ Wife 妻子 □ Daughter 女兒 □ Son 兒子
中文姓名:	□ Relative 親戚
	☐ Other:
Mobile Phone 手提電話	Preferred Contact Person 首選聯絡人:
	□ Applicant 申請人
	□ Person responsible for care 護理負責人
Respite Care 暫息護理□	Permanent Care 永久療養院護理 □
Respite Care Referral Code	Permanent Residential Care referral code
暫息護理推薦碼	永久療養院護理推薦碼
Please attach a copy of your assessment – ACCR	Please attach a copy of your assessment – ACCR assessment/Support Plan
assessment/Support Plan	請附上您的老年護理全面評估/支持計劃
請附上您的老年護理全面評估/支持計劃	
Part C: Your aged care histo	rv 你的老午莲理歷史
1. Have you ever been a permaner	
您曾經是其他療養院的永久居民嗎?	·
□Yes 是 Name of previous provio	
□No 否	
2. Are you currently living in another	er aged care facility?
您目前在另一間療養院住嗎?	
Name of provider 療養院名稱	
Date of admission 入住日期	
3. You currently live with 您目前是	
·	dent child 受撫養子女 □ family 家人
□ friends 朋友 □ by yours	self 獨居
4 What is your current type of coor	ommodation 你日前的住宅粞刑?
4. What is your current type of accommodat☐ Full owned private accommodat	
☐ Partly owned private accommod	
☐ Private accommodation owned by	
家人/朋友/其他人擁有的私人住所	
□ Rented property 租屋 □ F	
	Others 其他
	- /\



5. Are you currently receiving home care serv 您目前正在接受家居護理服務嗎?	ices? □ No 否 □Yes 是
If Yes, is it provided by ANHF Home Care Ser 如果是, 是否由澳華養老提供嗎?	□ No 否 □Yes 是
If your service is not provided by ANHF, pleas	
務不是由澳華養老提供,請列出提供者的名稱:	•
Please tick the services you are receiving 請勾	
□ Home Care Package 家居護理配套服務	
☐ Commonwealth Home Support Program (e	.g. Seniors Wellness Centres or
Domestic Assistance) 聯邦家居支援服務 (如:	•
6. Is your Spouse/Partner Applying at the sam	ne time 您的配偶/伴侶是否同時申請?
(a separate application form is required for ea	
□ No 否 □Yes 是	, , , , , , , , , , , , , , , , , , , ,
Spouse/Partner Name 配偶/伴侶姓名:	
Please provide his/her Reference Code if known	wn 如果知道請提供他/她的參考代碼
For example 如: XX/XX (M)	
7.Does your spouse/partner already reside in	,
您的配偶/伴侶是否已經居住在我們的療養院?	
(Please state the facility name 請提供療養院的	的名稱:
Part D: Financial Details 財政資料	
Financial Status 財政狀況	
□Full Pensioner 全福利金領受者 □Part Pens	
□Self-funded Retiree (non-Pensioner) 自費退	,
If you are a full /part pensioner, please tick	,
below: 如是全/半福利金領受者,請在下面勾	
選:	will undertake the <u>Means-test</u> assessment with Services Australia:
□ Centrelink – Services Australia 澳大利亞	如果您是自費退休人士(非福利金領
民政部	受者),請説明您是否願意接受澳大
□ DVA (non-means tested) 非入息審査	利亞民政部的經濟狀況調查評估。
□ DVA (means tested) 入息審査	□ Yes 是
□ Overseas 外國福利金 Please provide a copy of your Income and Assets	□ No 否
Determination letter from Service Australia that is	If you won't, you will be required to
issued within 3 months before admission to assist us	complete a means-non-disclosed statement.
working out your accommodation costs and fee. 請您	如果您不這樣做,您將需要填寫一份將不
提供一份在入院前 3 個月內由澳大利亞民政部簽發	會披露經濟狀況的聲明。 Please refer to Services Australia website for
的收入和資產確定函的副本,以便我們幫助您計算 住宿費用。	details: 詳情請參閱澳大利亞民政部網站
正旧	https://www.servicesaustralia.gov.au/resid
	ential-aged-care-means-
	assessment?context=23391

Pension number	福利金號碼			DVA number 退伍	i軍人福利金號碼
Card expiry date	rd expiry date 到期日 Card expiry date 到期日			到期日	
Part E: Med	ical Details	醫療資料			
	Phone 電話號碼 現任家庭醫生名字 Dementia Diagnosis 腦退化症的確證 □Yes 是 □No 否				
Dementia Diag	gnosis 腦退化	症的確證	□Yes 是	是 □No 否	
Medicare no.	Ref no. Expiry Date 過期日				
Private Health	Fund (if have)私人健愿	東保險 ()	如有): □Yes 是	Ŀ□No 否
Membership n	o. 會員號碼				
Part F: Requ	uest for Pri	ority Ad	missio	n優先錄取請求	
or any other g	rounds, please	e give det	ails belo		cial, social, medical 将任何理由出於經 供詳細資訊:

Part G ANHF Privacy Policy 澳華療養院基金私隱政策

We respect and maintain the privacy and confidentiality of our staff, volunteers, applicants, care recipients and tenants. This includes privacy and confidentiality of their personal and sensitive information, of their person and of their environment and belongings.

We also maintain the privacy and confidentiality of carers, authorised representatives, and visitors to our organisation and service sites.

We comply with all privacy related laws, regulations and the Australian Privacy Principles (APPs). We will take all reasonable steps to protect the personal information we hold from misuse and loss, and from unauthorised access, modification or disclosure.

We will only collect information directly from you with your consent. Your personal information will be managed authorised staff and personnel of ANHF. Your information is stored in a password protected database and will not be provided to any 3rd parties other than health services providers consent by you. If you would like to learn more on how we collect, keep and safeguard your information, please contact us in writing.

We would like to remind you to avoid sharing your personal information on the phone or by email, unless you are certain that the person contacting you is an ANHF staff with genuine and legitimate intention. When in doubt, please contact us for verification.

The Australian Competition and Consumer Commission provides useful information on how to protect yourself against scams on their SCAMwatch site https://www.scamwatch.gov.au/.

基金尊重及保障員工、義工、申請人士、護理對象及租客之私隱及保密權利,包括個人敏感資料、個人情況、個人環境及個人財物。

基金亦保障機構範圍及服務地點內之照顧者、獲授權人士及訪客之私隱及保密權利。

基金依循所有與私隱有關之法例、規章及「澳洲私隱綱領」(Australian Privacy Principles)之法則,亦採取所有合理步驟保障基金儲存之個人資料不被濫用或遺失,也不在未經授權下被取得、修改或透露。

本機構只在你同意下才會收集你的個人資料,所有資料由獲授權職員或人士處理,並儲存於必須經密碼開啓之數據庫內,絕不向第三者透露。若需透露予醫護人員,亦須經你事先同意。若要進一步了解基金如何收集、儲存及保障你的個人資料,請書面知會本機構。

謹提醒各位:除肯定與你接觸之人士為有真確及合法意向之澳華療養院基金職員外,應避免使用電話或電郵發送個人資料。若有任何懷疑,請聯絡本機構查證。

請參看「澳洲商業競爭及消費者專署」(Australian Competition and Consumer Commission)網址 SCAMwatch 網址 https://www.scamwatch.gov.au/

(中文僅供參考)



Part H Applicant Signature 申請人簽名	
Signature 簽名	Date 日期
Or 或	
If the applicant is unable to sign, the signa	ature that appears helow must be the
same person who was listed as the perso	··
Nomination of Authority & Contact Details	•
provided.	
如果申請人無法簽名, 護理負責人(即為	表格[RS6009 委托及授權人聯絡資料]列爲
護理負責人的同一人)可以代簽,同時必須	-
Name (Authorised Person):	Relationship/Authority 關係/權限
姓名(授權人):	☐ Guardian / NSW Public Trustee &
	Guardian* 監護人 / 新州公共信託人及監
	護人專署*
	*please supply a copy of Enduring
	Guardianship documentation
	*請提供一份持久監護人委託文件
	☐ Spouse or De facto Spouse
	配偶或同居伴侣
	□ Unpaid Carer 無薪照顧者
	☐ Relative – please specify relationship
	親屬-請註明關係
	□ Friend 朋友
Signature (Authorised Person):	Date:
簽名(授權人):	日期:

RS6009 – Nomination of Authority & Contact Details (E&C)_V2.0

Facility:	Wing / Room Number:				
D. I. U. E. (N					
Resident's First Name:		Family Name:			
Resident's Name in		Preferred			
Chinese: This nomination form is		Name:			
effective from:	_	_			
	From To				
☐ New Authority (Complete all sections)	☐ Amended Authority (Complete Page changed.)	1 of this form; and any	y sections that have		
	Description of Authorities				
Power of Attorney A Power of Attorney is a legal document allowing another person or agent to act on your behalf in matters to do with money, bank accounts, shares, real estate and other assets. A person or agent with Power of Attorney is only authorised to act in relation to financial matters. They are not authorised to make personal decisions (including medical decisions) on your behalf. In NSW there are two types of Powers of Attorney: 1. General Power of Attorney (also called an Ordinary Power of Attorney) A general (or ordinary) power of attorney is appointed for a specific period of time, e.g. during the time of an overseas holiday. If you appoint a General Power of Attorney and then lose mental capacity at a later stage the appointment will no longer be valid. 2. Enduring Power of Attorney An Enduring Power of Attorney is a legal document through which you can appoint a person to make decisions about your property or financial affairs. This can include spending and managing your money, buying or selling shares or buying, selling, leasing or mortgaging your house or other real estate. It remains in force after a person has lost mental capacity. Enduring Guardian is someone you legally appoint to make personal or lifestyle decisions for you when you are not capable of doing this for yourself. You choose which decisions you want your Enduring Guardian to make which may include where you should live and what medical treatment and services you should receive.					
	rts the people of NSW in planning for their futu s a person's financial manager and/or guardian				
	Confidentiality Information				
ANHF complies with the standards set out in the National Privacy Principles as defined in the Privacy Amendment (Private Sector) Act 2000. Therefore, we will only collect personal information if it is required to enable us to provide accommodation and care for our residents. We will only use or disclose information for the purpose for which it was collected and in ways that you would reasonably expect, unless you consent to it being used or disclosed in another way. We will not use the information for direct marketing purposes, nor disclose it to others for direct marketing purposes. We will take all reasonable steps to protect the personal information we hold from misuse and loss, and from unauthorised access, modification and disclosure. Full details of our Privacy Policy can be found in https://www.anhf.org.au/contact-us/privacy-policy/					
	following person(s) to represent me in r n the residential aged care facility.	managing the diffe	erent aspects of my		
Resident's Signature:			Date:		
OR					
Resident's Person Responsib	sible for Care (refer to authority and evi le for Care):	dence provided	Date:		



Please ensure each authority is signed by the authorised person who accepts his/her responsibility.

A. Person Responsible for Care - Primary Contact

This is the person we will contact for care issues and incidents notifications. Except in an emergency, this person will give consent for medical and dental treatment if the resident does not have the capacity to consent.

Note: If a valid Advance Care Directive has been provided it will be used first to determine treatment.

Who Can Be A Person Responsible

It is not necessarily your closest relative and the term **Next of Kin** has no legal standing. A **Person Responsible** under the NSW Guardianship Act 1987 is ranked in the following orders:

• A legally appointed Guardian (which includes Enduring Guardian or NSW Public Trustee & Guardian appointed by you – see **Description of Authorities**).

 If there is no quardian, a sp 			
partners).	ouse or de-facto spouse with whom you ha	ve a close continuing rel	ationship (includes same sex
 If there is no spouse or de fa residential care. 	acto spouse an unpaid carer who is now pro	viding support or provide	d support before you entered
 If there is no unpaid carer a 	relative or friend who has a close and contin	nuing personal relationsh	ip with you.
First Name:		Family Name:	
Or Organisation:			
Address Line 1:			
Address Line 2:			
Suburb:		Postcode:	
Phone:		Mobile:	
Email:			
Description of Person Responsible: Please tick appropriate box(s)	 ☐ Guardian / NSW Public Trustee & Guardianship documentation ☐ Spouse or De facto Spouse ☐ Unpaid Carer ☐ Relative – please specify relationship _ ☐ Friend 		ppy of Enduring
I agree to accept responsibi Signature:	lity as a Person Responsible for Care		Date:
Other Remarks:			
☐ Tick this box if there is m	ore than 1 person responsible for Care	and complete the next	section.
☐ Tick this box if the person	n responsible for Care requires support	for languages other th	on English If so places
specify the language require		ioi ialiguages otilei tii	an English. If so, please
specify the language require	ed for spokerr/ writterr		
medical and dental tre	tact – This person will only be conta atment if (1) the primary person resp the capacity to consent.		
medical and dental tre resident does not have		onsible for Care is ur	
medical and dental tre resident does not have First Name:	atment if (1) the primary person resp		
medical and dental tre resident does not have First Name: Or Organisation:	atment if (1) the primary person resp	onsible for Care is ur	
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1:	atment if (1) the primary person resp	onsible for Care is ur	
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1: Address Line 2:	atment if (1) the primary person resp	onsible for Care is ur Family Name:	
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1:	atment if (1) the primary person resp	onsible for Care is ur Family Name: Postcode:	
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone:	atment if (1) the primary person resp	onsible for Care is ur Family Name:	
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email: Description of Person Responsible: Please tick appropriate box(s)	atment if (1) the primary person respective capacity to consent. Guardian / NSW Public Trustee & Guardianship documentation Spouse or De facto Spouse Unpaid Carer Relative – please specify relationship Friend	Postcode: Mobile: Ardian – please supply a	navailable AND (2) if the
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email: Description of Person Responsible: Please tick appropriate box(s) I agree to accept responsibile Signature:	atment if (1) the primary person respective capacity to consent. Guardian / NSW Public Trustee & Guardianship documentation Spouse or De facto Spouse Unpaid Carer Relative – please specify relationship	Postcode: Mobile: Ardian – please supply a	navailable AND (2) if the
medical and dental tre resident does not have First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email: Description of Person Responsible: Please tick appropriate box(s) I agree to accept responsibi	atment if (1) the primary person respective capacity to consent. Guardian / NSW Public Trustee & Guardianship documentation Spouse or De facto Spouse Unpaid Carer Relative – please specify relationship Friend	Postcode: Mobile: Ardian – please supply a	copy of Enduring



O Daman Danas and Ibla fo		
C. Person Responsible to	or Finances – Primary Contact	
	and to whom we will send all correspondence and consents relatir	ng to financial matters
including fees. RADs and monthly	statements. All financial matters should be referred to:-	ig to interioral mattere,
	Myself (the Resident) <i>OR</i> □ My Representative (below)	
First Name:	Family Name:	
Thousand.	T anny reality.	
Or Organization:		
Or Organisation:		
Address Line 1:		
Address Line 2:		1
Suburb:	Postcode:	
Phone:	Mobile:	
Email:		
Type of Authority Held:	Please tick appropriate box(s) and attach a copy of evider	ce if relevant See
(Refer to Description of	Description of Authorities for more information.	ioo ii roiovanii. Goo
Authorities on Page 1 of this	☐ General Power of Attorney (Not valid if the resident has lost of	ranacity)
	☐ Enduring Power of Attorney (Remains in force if the resident	
form).	□ NSW Public Trustee & Guardian	rias lost Capacity)
	☐ Relative – please specify relationship	
Lagree to accept responsibility	as a Person Responsible for Finances	Date:
Signature:	as a reison responsible for rillances	Date.
Signature.		
Other Remarks:		
☐ Tick this box if there is more	e than 1 person responsible for Finances and complete the	next section.
	esponsible for Finance requires support for languages other	r than English. If so,
please specify the language re	quired for spoken / written	·
5 A LUC		
D Additional Finances (3	ontact - This person will only be contacted for consent	for financial
	ontact – This person will only be contacted for consent	
matters/consents if (1) th	ne primary person responsible for Care is unavailable A	
matters/consents if (1) the does not have the capac	ne primary person responsible for Care is unavailable A ity to consent.	
matters/consents if (1) th	ne primary person responsible for Care is unavailable A	
matters/consents if (1) the does not have the capace First Name:	ne primary person responsible for Care is unavailable A ity to consent.	
matters/consents if (1) the does not have the capace First Name: Or Organisation:	ne primary person responsible for Care is unavailable A ity to consent.	
matters/consents if (1) the does not have the capace First Name:	ne primary person responsible for Care is unavailable A ity to consent.	
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1:	ne primary person responsible for Care is unavailable A ity to consent.	
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2:	ne primary person responsible for Care is unavailable A ity to consent. Family Name:	
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2: Suburb:	re primary person responsible for Care is unavailable A ity to consent. Family Name: Postcode:	
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone:	ne primary person responsible for Care is unavailable A ity to consent. Family Name:	
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email:	re primary person responsible for Care is unavailable A ity to consent. Family Name: Postcode: Mobile:	ND (2) if the resident
matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email: Type of Authority Held:	Please tick appropriate box(s) and attach a copy of evider	ND (2) if the resident
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matters/consents if (1) the does not have the capace First Name: Or Organisation: Address Line 1: Address Line 2: Suburb: Phone: Email: Type of Authority Held: (Refer to Description of	Please tick appropriate box(s) and attach a copy of evider Description of Authorities for more information. General Power of Attorney (Not valid if the resident has lost of Enduring Power of Attorney (Remains in force if the resident	ND (2) if the resident acce if relevant. See
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	Contact / Advo	cate 1	
First Name:		Family Name:	
Or Organisation:			
Address Line 1:			
Address Line 2:			
Suburb:		Postcode:	
Phone:		Mobile:	
Email:		1	
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I agree to be a contact / an adv Signature:	ocate for the resident.		Date:
Other Remarks:			
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First Name:		Family Name:	
Or Organisation:			
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I agree to be a contact / an adv Signature:	ocate for the resident.		Date:
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RS6009 — 委託受權人及聯絡資料				
院舍:		翼樓/		
		房間號碼:		
名(First Name):		姓 (Family Name):		
院友中文名字:		選擇稱謂:		
本委任表格生效日期:		•		
	自至	或 🛘 直至另行数	通知	
口 委託新受權人 (填寫所有項目)	□更改受權人(填寫本表格第一頁及其	其他任何須更改的部分	`)	
	授权简介			
授權書 Power of Attorney 授權書是一份準予另一位人士或代理機構代表你在金錢、銀行賬目、股票、物業及其他資產等事宜上代行的法律文件。 持有授權書的人士或代理機構只獲授權代為處理財務事宜,不獲授權你作出個人決定(包括醫療決定)。新州有兩種授權書: 1. 一般授權書(General Power of Attorney,又稱Ordinary Power of Attorney) 一般授權書只委託一段指定時間,例如在海外旅行期間。若你選擇一般授權書但其後失去理解常理的能力,這委託便不再生效。 2. 持久授權書(Enduring Power of Attorney) 持久授權書是一份容許你委託一位人士代你決定物業或財務事宜的法律文件,可以包括使用及處理你的金錢、購買或出售股票、租出或按押你的房屋或其他物業。持久授權書在委託人失去理解常理的能力後仍然生效。 持久監護人 Enduring Guardianship 持久監護人是一位經你合法委託的人士,在你沒有能力自行作出決定時代你作出個人或生活上的決定。你可以要求你的持久監護人作出那些決定,例如你要居住在那裏和想要那些醫療及服務。 新州信託人及監護人專署 NSW Trustee & Guardian				
<i>託這代理機構作為其個人財務經理及/或監護人。</i> 資料保密				
澳華療養院基金依循「2000 年私隱(私人範疇)修訂法例」(Privacy Amendment (Private Sector) Act 2000)釐定的「全國私隱綱領」(National Privacy Principles),由是基金只收集與為院友提供住宿及護理所需的資料。我們只會接收集資料的目的或你按常理預期的情況下才使用或透露這些資料。基金不會將這些資料直接用作市場推廣,也不會向他人透露作市場推廣之用。我們會採取所有合理步驟保障基金持有的個人資料,確保不被濫用或遺失、杜絕未經授權而接觸、更改及透露資料。基金私隱政策詳見https://www.anhf.org.au/contact-us/privacy-policy/				
□ 本人同意授權下列人士在本人入住院舍期間代表本人處理各種個人事宜				
院友簽署:			日期:	
或	1		I	
	理受權人及證明文件一欄):		日期:	



請確保每一位受權人簽署確認接受被授權之責任。

A. 護理受權人 — 主要聯絡人 Person Responsible for Care - Primary Contact

這是一位我們會聯絡有關護理事宜及通知事故的人士。除緊急情況外,這位人士將在院友沒有能力親自作出同意時代為同意醫護 及牙齒護理的安排。

注意:若已提供有效之「預立護理指引」(Advance Care Directive),則會按指引決定治療方法。 誰可作為受權人

受權人不需要是你的至親,即使「近親」這一名詞也無法律約束力。按「1987年新州監護人法例」(NSW Guardianship Act 1987) 「受權人」先後次序釐定如下:

• 一位按法律委託的監護人(包括由你委任的持久監護人或你自新州公共信託人及監護人專署委任的人士 — 參看授權簡介)

	你有持續緊密關係的配偶或伴侶(包括同性伴们		
	為現在或在你入住院舍前支援你的無薪照顧者為與你有持續緊密關係的一位親屬或朋友	•	
名(First Name):		姓(Family Name):	
或機構名稱:		X±(1'allilly Ivallic).	
地址(第1行):			
地址(第2行):			
地區:		郵政號碼:	
電話:		手機:	
電郵:		7 0/3	l
受權人類別::請在合適 方格内打鉤	□ 監護人 <i>I 新州公共信託人及監護人專署(</i> 下請提供一份持久監護人委託文件 □ 配偶或同居伴侣 □ 無薪照顧者 □ 親屬 - 請註明關係	NSW Public Trustee & Gua	rdian) –
本人同意接受護理受權人的 簽署:			日期:
其他意见:			
	·位護理受權人,則在此方格内打鉤 〉之語言支援,則在此方格内打鉤。若有此	需要,請註明所需之[□述/書面語言。
	ロナ / 1 / 毎 / 1 m / m / m / m / m / m / m / m / m /		
	只在(1)無法聯絡主要護理受權人及(2)		司意時才會聯絡這位人士
名 (First Name):)院友没有能力作出同 姓(Family Name):	司意時才會聯絡這位人士
名(First Name): 或機構名稱:			司意時才會聯絡這位人士
名 (First Name) : 或機構名稱 : 地址 (第 1 行) :			可 意時才會聯絡這位人士
名(First Name): 或機構名稱: 地址(第1行): 地址(第2行):		姓(Family Name):	可 意時才會聯絡這位人士
名 (First Name): 或機構名稱: 地址 (第 1 行): 地址 (第 2 行): 地區:		姓(Family Name): 郵政號碼:	司意時才會聯絡這位人士
名(First Name): 或機構名稱: 地址(第1行): 地址(第2行): 地區: 電話:		姓(Family Name):	司意時才會聯絡這位人士
名 (First Name): 或機構名稱: 地址 (第 1 行): 地址 (第 2 行): 地區:		姓(Family Name): 郵政號碼: 手機:	
名(First Name): 或機構名稱: 地址(第1行): 地址(第2行): 地區: 電話: 電郵: 受權人類別::請在合適方	□ 監護人 / 新州公共信託托人及監護人專署 請提供一份持久監護人委託文件 □配偶或同居伴侣 □無薪照顧者 □親屬 - 請註明關係	姓(Family Name): 郵政號碼: 手機:	
名(First Name): 或機構名稱: 地址(第1行): 地址(第2行): 地區: 電話: 電郵: 受權人類別::請在合適方格內打鉤	□ 監護人 / 新州公共信託托人及監護人專署 請提供一份持久監護人委託文件 □配偶或同居伴侣 □無薪照顧者 □親屬 - 請註明關係	姓(Family Name): 郵政號碼: 手機:	Guardian) -
名 (First Name): 或機構名稱: 地址 (第 1 行): 地址 (第 2 行): 地區: 電話: 電郵: 受權人類別::請在合適方格內打鉤	□ 監護人 / 新州公共信託托人及監護人專署 請提供一份持久監護人委託文件 □配偶或同居伴侣 □無薪照顧者 □親屬 - 請註明關係	姓(Family Name): 郵政號碼: 手機:	Guardian) -
名(First Name): 或機構名稱: 地址(第1行): 地址(第2行): 地區: 電話: 電郵: 受權人類別::請在合適方格內打鉤 本人同意接受護理受權人的簽署: 其他意见:	□ 監護人 / 新州公共信託托人及監護人專署 請提供一份持久監護人委託文件 □配偶或同居伴侣 □無薪照顧者 □親屬 - 請註明關係	姓(Family Name): 郵政號碼: 手機: 写(NSW Public Trustee &	Guardian)-



超是一位表們會聯絡及發出所有與財務(包括費用・可题问性的按金及月結單)有關的通訊及同意事宜的人士。所有財務事宜。 一本人 (版		3人 Person Responsible for Finances		
□ 本人(院友) 或 □ 本人代表(如下) 名(First Name): 或機構名稱: 地址(第1行): 地址(第1行): 地址(第2行): 地區: 電話: 電話: 電話: 養育: 養育: 養育: 養育: 養育: 世報(開別:(参看本表格首頁) □ 一般提傳者:芒散及夫夫亞法別無效 □ □ 長段權者:芒散及夫夫亞法別無效 □ 和國子法院法人及監查、專署 和人同意接受財務受權人的責任 签署: 具他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若射務受權人需要英語外之語言支援,則在此方格內打鉤。 □ 若射務受權人需要英語外之語言支援,則在此方格內打鉤。 □ 若射務受權人需要英語外之語言支援,則在此方格內打鉤。 □ 老財務 等 值作出同意時,才輸給這位人士 名(First Name): 建姓丘(第1行): 建址(第1行): 提維衛介) □ 一般授權者(若能及失去在決策力則無效 □ 持久提權所介) □ 一般授權者(若能及失去自決力的無效 □ 「持久提權所介) □ 長稅權所介 □ 「持久提權所介」 □ 「持久提信人及監護、專署 本人同意接受財務受權人的責任 簽署: 其他意见: □ 相談 □ 日期:		財務(包括費用、可退回住宿按金及月結	單)有關的通訊及同意事	宜的人士。所有財務事宜須
攻機博名編: 地址(第1行): 地址(第2行): 地址(第2行): 地址(第2行): 地區:電話: 一	田十列八工炮柱。	□ 本人(院友) 或 □ 本人(代表(如下)	
攻機博名編: 地址(第1行): 地址(第2行): 地址(第2行): 地址(第2行): 地區:電話: 一	7 (F' (N) ·	T	bil (E '1 N	
地址(第1行): 地址(第2行): 地址(第2行): 地址(第2行): 地域(第2行): 一种投稿書(音節次大生台中能力的然生效) 一科大技能意(人專著) 一科大技能意(人專著) 一 報酬	名 (First Name):		姓 (Family Name):	
地址 (第2行): 地區:				
世區: 郵政號碼: 子機: 電郵: 子機: 電郵: 子機: 電郵: 子機: 電郵: 子機: 電郵: 技権類別: (参看本表格首頁 授権前介) 日級権害 (名院女夫五日永能力明無效) 日本 (本民 大田				
電話: 電影: 「			郵(功)地研・	
電郵: 按機關別: (参看本表格首頁 按機簡介) □ 一般授權書(若院友失去自决能力則無效) □ 特久授權書(若院友失去自决能力則無效) □ 粉州公共信託人及監護、專署 □ 報局 - 請註明關係 本人同意接受財務受權人的責任 签署: 其他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之口越/害面語言。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之口越/害面語言。 □ 花財務事實作出同意時,才聯絡這位人士 在 (First Name): 或機構名稱: 地址(第1行): 地址(第1行): 地址(第2行): 地址(第2行): 地址(第2行): 地址(第2行): 地址(第2行): 地址(第2行): 地址(第2行): 地域(第2行): 日期: 養書: 其他意见:				
□ 一般接權書(若院友失去自共能力則無效) □ 持久榜權者(若院友失去自共能力則無效) □ 持八久陰應人與管理 (若院友失去自共能力則無效) □ 報屬 - 請註明關係 本人同意接受財務受權人的責任 签署: 其他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□遞/書面語言。 □ 整好務夢宣作出同意時,才聯絡這位人士 名(First Name): 或機構名稱: 地址(第1行): 地址(第1行): 地址(第1行): 地址(第1行): 地址(第1行): 地址(第1行): 地址(第1行): 地址(第1行): 地域(第2行): 地域(第4件) □ 一級授權書(若院友失去自共能力則無效) □ 新及號碼: 電話: 電郵: □ 一級授權書(若院友失去自共能力則無效) □ 所州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和州公共信託人及監護人專書 □ 和明 · 請註明關係 本人同意接受財務受權人的責任 簽署: □ 其他意见:			3 1/4	
□ 持久投權書(若院友失去自決能力仍然生效) □ 新州公共信託人及監護人專署 □ 親屬 - 請註明關係 本人同意接受財務受權人的責任 签署: 其他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □ 2. 				見 授權簡介)
本人同意接受財務受權人的責任 签署: 其他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □	授權简介)	□ 持久授權書 (若院友失去自决能力(I □ 新州公共信託人及監護人專署		
其他意见: □ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之口述/書面語言。 □ 初外財務聯絡人 — 只在(1)無法聯絡主要護理受權人及(2)院友沒有能力作出同意時才會聯絡這位土就財務事宜作出同意時,才聯絡這位人士 名(First Name):	本人同意接受財務受權人的責任			日期:
□ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □	签署:			
□ 若在下一部分填寫超過一位財務受權人則在此方格內打鉤。 □ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □	其他意见:			
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□ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □ 類外財務聯絡人一 只在(1)無法聯絡主要護理受權人及(2)院友沒有能力作出同意時才會聯絡這位 土就財務事宜作出同意時,才聯絡這位人士 名(First Name): 姓 (Family Name): □ 或機構名稱: □ 地址(第1行): □ 地址(第2行): □ 地區: □ 電話: □ 電話: □ 雪郵: [授權類別:(參看本表格首頁] 一般授權書(若院友失去自決能力則無效) □ 持久授權書(若院友失去自決能力則無效) □ 持久授權書(若院友失去自決能力仍然生效) □ 新州公共信託人及監護人專署 □ 親屬 - 請註明關係 本人同意接受財務受權人的責任 簽署: 其他意见:				
□ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明所需之□述/書面語言。 □ 類外財務聯絡人一 只在(1)無法聯絡主要護理受權人及(2)院友沒有能力作出同意時才會聯絡這位 土就財務事宜作出同意時,才聯絡這位人士 名(First Name): 姓 (Family Name): □ 或機構名稱: □ 地址(第1行): □ 地址(第2行): □ 地區: □ 電話: □ 電話: □ 雪郵: [授權類別:(參看本表格首頁] 一般授權書(若院友失去自決能力則無效) □ 持久授權書(若院友失去自決能力則無效) □ 持久授權書(若院友失去自決能力仍然生效) □ 新州公共信託人及監護人專署 □ 親屬 - 請註明關係 本人同意接受財務受權人的責任 簽署: 其他意见:	口 艺士下,郊八镇宿却温,台	时效 妥雄【即左处主权由行始。		
D. 額外財務聯絡人一只在(1)無法聯絡主要護理受權人及(2)院友沒有能力作出同意時才會聯絡這位 士就財務事宜作出同意時,才聯絡這位人士 名(First Name): 姓(Family Name): 或機構名稱: 地址(第1行): 地址(第2行): 郵政號碼: 電話: 手機: 電話: 手機: 電郵: 一般授權書(若院友失去自決能力則無效) 一件久授權書(若院友失去自決能力仍然生效) 一將八投權書(若院友失去自決能力仍然生效) 一將八投權書(若院友失去自決能力仍然生效) 財務受權人的責任 有期: 養署: 其他意见:				
土就財務事宜作出同意時,才聯絡這位人士 名 (First Name): 姓 (Family Name): 或機構名稱: 地址 (第1行): 地址 (第2行): 郵政號碼: 電話: 手機: 電郵: 手機: 電郵: 持機: 電郵: 一般授權書(若院友失去自决能力則無效) 一般授權書(若院友失去自决能力仍然生效) 持久授權書(若院友失去自决能力仍然生效) 新州公共信託人及監護人專署 親屬 - 請註明關係 本人同意接受財務受權人的責任 日期: 簽署: 日期:	□ 岩財務受權人需要英語外之	語言支援,則在此万格內打鉤。若有即	比需要,請註明所需乙	□延/書面語言。
土就財務事宜作出同意時,才聯絡這位人士 名 (First Name): 姓 (Family Name): 或機構名稱: 地址 (第1行): 地址 (第2行): 郵政號碼: 電話: 手機: 電郵: 手機: 電郵: 持機: 電郵: 一般授權書(若院友失去自决能力則無效) 一般授權書(若院友失去自决能力仍然生效) 持久授權書(若院友失去自决能力仍然生效) 新州公共信託人及監護人專署 親屬 - 請註明關係 本人同意接受財務受權人的責任 日期: 簽署: 日期:				
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名 (First Name): 姓 (Family Name): 或機構名稱: 地址 (第1行): 地區: 郵政號碼: 電話: 手機: 電郵: 持機: 授權預別: (参看本表格首頁 授權简介) 請在合適方格打鉤及附上有關證明文件 (若需要)。 (詳見授權簡介) 一般授權書(若院友失去自决能力則無效) 持久授權書(若院友失去自决能力則無效) 新州公共信託人及監護人專署 親屬 - 請註明關係 本人同意接受財務受權人的責任 簽署: 日期: 其他意见: 其他意见:			2)院友沒有能力作品	出同意時才會聯絡這位人
地址 (第1行): 地址 (第2行): 地區: 電話: 電話: 電郵: 授權類別: (参看本表格首頁			姓 (Family Name):	
地址(第 1 行): 地址(第 2 行): 地區: 郵政號碼: 電話: 手機: 電郵: 授權類別:(参看本表格首頁				
地址 (第 2 行) : 郵政號碼: 郵政號碼: 電話: 手機: 手機:				
地區: 郵政號碼: 手機: 電話: 手機: 手機: 手機: 手機: 手機: 手機: 手標類別: (参看本表格首頁 請在合適方格打鉤及附上有關證明文件(若需要)。(詳見 授權简介) 一般授權書(若院友失去自决能力則無效) 一持久授權書(若院友失去自决能力仍然生效) 一 新州公共信託人及監護人專署 一 親屬 - 請註明關係 日期:				
電話:			郵砂號碼:	
電郵: 授權類別:(參看本表格首頁				
授權類別: (參看本表格首頁			1 1/24	
□ 持久授權書(若院友失去自决能力仍然生效) □ 新州公共信託人及監護人專署 □ 親屬 - 請註明關係 □		請在合適方格打鉤及附上有關證明文	て件(若需要)。 (詳	見 授權簡介)
美相意见:	授權简介)	□ 持久授權書 (若院友失去自决能力(I □ 新州公共信託人及監護人專署		
				日期:
□ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明明所需之□述/書面語言。	其他意见:			1
□ 若財務受權人需要英語外之語言支援,則在此方格內打鉤。若有此需要,請註明明所需之□述/書面語言。				
□ 若財務受權人需要英語外之語言支援,則在此方格内打鉤。若有此需要,請註明明所需之□述/書面語言。)		
	□ 若財務受權人需要英語外之	語言支援,則在此方格内打鉤。若有』	比需要,請註明明所需	之口述/書面語言。



E. 其他有意參與人士 / 代言。		Advocates	
在下面列出任何可能有意參與你個			
	第一位聯絡人		
名(First Name):		姓 (Family Name):	
或機構名稱:			
地址(第1行):			
地址(第2行):			
也區:		郵政號碼:	
電話:		手機:	
電郵:			
受權類別:(參看本表格首頁	請在合適方格打鉤及附上有關		并見 授權簡介)
授權简介)	□ 一般授權書(若院友失去自) □ 持久授權書(若院友失去自) □ 新州公共信託人及監護人專署 □ 親屬 - 請註明關係	夬能力仍然生效)	
本人同意作為上述院友之聯絡 <i>)</i> 簽署:	八代言人		日期:
其他意见:			
	第二位聯絡人	./代言人	
名(First Name):		姓 (Family Name):	
或機構名稱:		•	•
也址(第1行):			
也址(第2行):			
也區:		郵政號碼:	
電話:		手機:	
電郵:		1	-
受權類別:(參看本表格首頁	請在合適方格打鉤及附上有關	關證明文件(若需要)。 (語	并見 授權簡介)
授權简介)	□ 一般授權書(若院友失去自為 □ 持久授權書(若院友失去自为 □ 新州公共信託人及監護人專業 □ 親屬 - 請註明關係	夬能力仍然生效)	
本人同意作為上述院友之聯絡 <i>)</i> 簽署:	八代言人		日期:
其他意见:			
F・通訊			
請将本人所有通訊(與基金有關之 若你的代表與 護理受權人或財務受 □護理受權人 - 主要聯絡人 □護理受權人 - 额外聯絡人	⋛權人為同一人 ,請指明: □ 財務受權人 - 主要聯絡。	人	表
名(First Name):		姓(Family Name):	
或機構名稱:			
地址(第1行):			
也址(第2行):			
也區:		郵政號碼:	
電話:		手機:	
電郵:		•	•
於室用: □ Undated in Finance	on By	☐ Undated in PCS on	Rv

