Application for Residency

Minchinbury Manor

About this application

Why we ask these questions
This application helps us understand your health, history, preferences, and values so we can provide care that reflects *who you are*. Every question serves an important purpose — to ensure your care starts smoothly, your wishes are respected, and your wellbeing is fully supported.

Need Help?
Our team can help you complete this form if needed.

Application Completion Checklist
Use this checklist to ensure all sections are completed and required documents attached before submitting your application. *(Tick each box once reviewed.)*

Check the box once each section has been reviewed and completed.

Application Completion Checklist	Completed	Notes / Comments
About You	☐	
Your Nominated Contacts	☐	
Your Legal Details & Preferences	☐	
Your Medical and Health Information	☐	
Religious, Spiritual & Cultural Information	☐	
Advance Care Planning & End-of-Life Wishes	☐	
Personal Information Use Consent Form	☐	
Authority to Consent Form	☐	
Message Manager Communication Consent Form	☐	
Responsibility for Fees Form	☐	
Direct Debit Request (DDR) Form	☐	
Please attach certified or legible copies of the following documents (where applicable) to support your application		
Current GP Medical Summary / medication list	☐	
Relevant Medical Reports – specialist letters	☐	
Certified copies of POA/Guardianship	☐	
Copy of Pension Card /Health Care Card/ DVA Card	☐	
Copy of Medicare Card	☐	
Copy of Private Health Fund Card	☐	
Vaccination Record Summary – Influenza and COVID	☐	
Advance Care Directive or Advance Care Plan	☐	
Identification of Registered Supporter (if nominated)	☐	
Guardianship / Administration Orders (if applicable)	☐	
Income and Assets Determination Letter from Services Australia or DVA, if available	☐	

Privacy Collection Statement

Minchinbury Manor respects your privacy and is committed to protecting your personal information in accordance with the Privacy Act 1988 (Cth), the Australian Privacy Principles (APPs 1–13), the Aged Care Act 2024 (Cth), and the Aged Care Rules 2025.

Why we collect your information
We collect personal and, where necessary, sensitive or health information about individuals to:

- provide and manage safe, high-quality care and services;
- meet our obligations under aged care, workplace, and privacy legislation;
- communicate with representatives, family members, health practitioners, and other authorised persons;
- administer employment, contracting, and training functions; and
- maintain accurate organisational records for reporting, safety, and quality purposes.

How we collect your information
Personal information is usually collected directly from you, but may also be obtained from an authorised representative, health professional, referee, or another lawful source such as a government agency, hospital, or education provider.

Who we share it with
Your information may be disclosed to:

- treating health professionals or service providers involved in care or workplace support;
- government agencies such as the Department of Health and Aged Care or the Aged Care Quality and Safety Commission;
- insurers, auditors, and professional advisers; or
- others as required or authorised by law.

How we protect it
Minchinbury Manor stores all information securely within Australia. Information will not be disclosed overseas unless required by law or with your express consent.

You may request access to, or correction of, your personal information at any time by contacting the Facility Manager.

If you have any privacy concerns, please contact the Facility Manager.

If your concern is not resolved, you may contact:

- Aged Care Quality and Safety Commission – www.agedcarequality.gov.au/making-complaint/lodge-complaint | 1800 951 822
- Office of the Australian Information Commissioner (OAIC) www.oaic.gov.au/privacy/privacy-complaints

This Privacy Statement should be read together with Minchinbury Manor's Privacy Policy, available at the facility or can be provided free of charge upon request.

Your application

About you: The person requiring residential aged care

Title	☐ Mr	☐ Mrs	☐ Ms	☐ Other
Surname				
Given Name(s)				
Current residential address				
Street number		Street name		
Suburb		State		Postcode
Phone (Day)		Phone (Night)		
Mobile		Email		
Marital status	☐ Single	☐ Married	☐ Defacto	☐ Widowed ☐ Divorced
Date of birth	D D M M Y Y Y Y			
Gender	☐ Male	☐ Female	☐ Other	
Country of birth		Aboriginal/Torres Strait Islander	☐ Yes	☐ No
Preferred language	☐ English		Other (specify)	
Require an interpreter	☐ Yes	☐ No		
Name of someone who can assist with interpreting if necessary				
Phone		Email		
Your religion				

Your pension status

Pension status	☐ Full pension	☐ Part pension	☐ No pension
Pension from	☐ Centrelink	☐ DVA	☐ Other
Type of pension (e.g. Age, disability etc.)			
Pension number		Card expiry date	
DVA number		Card expiry date	
	☐ Red	☐ Blue	☐ Gold ☐ White ☐ Other

Your health care

Name of your general practitioner					
Surgery address					
Phone number		Email			
Medicare card no		Expiry date		Reference no	
If you have private health cover, please complete:					
Name of fund		Membership no			
Level of cover		Do you have ambulance cover?	☐ Yes	☐ No	

Name of your other health care practitioner			
Field of specialty			
Surgery address			
Phone number		Email	

Name of your other health care practitioner			
Field of specialty			
Surgery address			
Phone number		Email	

Name of your other health care practitioner			
Field of specialty			
Surgery address			
Phone number		Email	

Name of your pharmacy			
Address			
Phone number		Email	
PBS Safety net number			

Your partner

Do you have a spouse or partner?	☐ Yes	☐ No	
Spouse/partner name			
Are you and your spouse/partner applying together for a place in aged care?	☐ Yes	☐ No	
Does your spouse/partner already live in a residential care home?	☐ Yes	☐ No	
Name of aged care home			
Address			

Your living arrangements

Who do you currently live with?	☐ Spouse/partner	☐ Alone	☐ Family/friends	☐ Carer
Where do you live?	☐ Own home	☐ Rented home	☐ Family/friends	☐ Hospital
	☐ Retirement village	☐ Other residential aged care – specify below:		
Name of aged care home				
Address				
Is your current care	☐ Respite	☐ Permanent		
Date you entered current aged care home	D D M M Y Y Y Y			

Your previous aged care experiences

Have you ever been a resident in residential aged care in the past?	☐ Yes	☐ No		
If yes, indicate whether	☐ Respite	☐ Permanent		
If respite, how many days of respite have been used since 1 July of this year?				
Name of previous aged care home				
Date of entry to previous home	D D M M Y Y Y Y			
Date you departed previous home	D D M M Y Y Y Y			
Accommodation bond paid	$		Accommodation charge	$
Means tested fee	$			

Your Nominated contacts

Whenever possible, we will always talk to you, about the care and services we provide to you. However, we ask that you please nominate a trusted person/s whom we can contact if necessary.

Primary contact details

Title	☐ Mr	☐ Mrs	☐ Ms	☐ Other
Full name				
Primary contact's residential address				
Street number		Street name		
Suburb		State		Post code
Phone (day)		Phone (night)		
Mobile		Email		
I give permission for this contact to have my personal information shared with them	☐ Yes	☐ No		
I give permission for this contact to receive all correspondence on my behalf	☐ Yes	☐ No		

Secondary contact details

Title	☐ Mr	☐ Mrs	☐ Ms	☐ Other
Full name				
Secondary contact's residential address				
Street number		Street name		
Suburb		State		Post code
Phone (day)		Phone (night)		
Mobile		Email		
I give permission for this contact to have my personal information shared with them	☐ Yes	☐ No		
I give permission for this contact to receive all correspondence on my behalf	☐ Yes	☐ No		

Billing contact

Who should receive bills related to your care?

☐ I should (the resident)	☐ Primary contact	☐ Secondary contact
☐ Other contact (please complete below)		

Billing contact details

Full name			
Relationship to you			
Organisation name (if applicable)			
Phone number		Email	

Your legal details and preferences

Please make sure that you have supplied certified copies of the relevant documentation to support details below.

Do you have an Enduring Power of Attorney and/or Enduring Guardianship appointment?	☐ Yes	☐ No
Document description		
Full name and phone number of person appointed under the document		
☐	Certified copy of relevant document/s attached	

Your Restrictive Practice Substitute Decision Maker (RPSDM) if applicable

If you are able to give informed consent to the use of restrictive practices, you have the right to **agree to or refuse** the use of any restrictive practice that affects you.
In **New South Wales**, this authority rests with:

- A **Guardian** appointed by the NSW Civil and Administrative Tribunal (**NCAT**) with a *restrictive practices function*; or
- An **Enduring Guardian** appointed by you while you had capacity, if their appointment includes a *restrictive practices function.*

If no guardian or enduring guardian is in place, the Commonwealth allows, under a temporary hierarchy, for another trusted person (such as a partner, relative, or close friend) to act as a Restrictive Practices Substitute Decision-Maker (RPSDM) until a formal appointment can be made.
This ensures that, even if formal arrangements are not yet in place, someone you trust can participate in important decisions about your care and safety.
You are encouraged to discuss your wishes with your family or representatives and to provide certified copies of any legal appointments (for example, Enduring Guardianship or NCAT Orders) when available.
If no legal substitute decision-maker is in place and you lack decision-making capacity:

- An application can be made to **NCAT** to appoint a guardian with the authority to make decisions about restrictive practices.

RPSDM details

Do you have a Substitute Decision-Maker for Restrictive Practices?			☐ Yes	☐ No
Type of authority	☐ Enduring Guardian *(appointed by you with restrictive practices function)*	☐ NCAT appointed Guardian	☐ Temporary Restrictive Practices Substitute Decision-Maker *(as per Commonwealth hierarchy)*	
Full name of Substitute Decision-Maker:				
Relationship to you				
Address				
Phone (day)		Phone (night)		
Mobile		Email		
☐	Certified copy of relevant document/s attached			

Your registered supporter (if applicable)

Under the new Aged Care Act (effective 1 November 2025), you may choose to have one or more **registered supporters** to help you understand, make, and communicate decisions about your aged care.
By identifying registered supporters, we can:

- support you to make your own decisions with assistance if you choose,
- respect your will, preferences, and decisions, including who you wish to be supported by and how that support should occur, and
- help your registered supporters perform their role appropriately by sharing and receiving information as authorised under the Aged Care Act 2024.

If you have a registered supporter, please complete the details below.
If you do not currently have a registered supporter, you may choose to nominate one later through My Aged Care.

Registered supporter details

Title	☐ Mr	☐ Mrs	☐ Ms	☐ Other
Full name				
Address				
Phone (day)		Phone (night)		
Mobile		Email		
☐	I confirm that I have chosen the above person to be my *registered supporter* to help me understand, make, and communicate decisions about my aged care.			
☐	I understand that this person supports me to make my own decisions and does not automatically have authority to make decisions on my behalf unless they hold a separate legal appointment (e.g. enduring power of attorney or guardian).			
Signature		Date	☐☐☐☐☐☐☐☐ D D M M Y Y Y Y	
Registered supporters signature		Date	☐☐☐☐☐☐☐☐ D D M M Y Y Y Y	
☐	Certified copy of relevant document/s attached			

Your medical and health information

Please provide a current Full Medical Summary printout from your doctor.
This ensures your current diagnoses, medications, and allergies are accurately recorded.

Allergies

Do you have any allergies (medication, food, or anything else)?	☐ Yes	☐ No

If yes, please specify the allergy and the reaction experienced below:

Allergy	Reaction

General physical condition

Weight (kgs)		Height (cms)	
Date of last flu vaccination	D D M M Y Y Y Y	Date of last COVID vaccination	D D M M Y Y Y Y
Do you smoke?	☐ Yes ☐ No	If yes, how often	
Do you drink alcohol?	☐ Yes ☐ No	If yes, how often	

Past surgical procedures and operations

Please list past surgical procedures and operations below:

Procedure / Operation	Year

Skin conditions

Please indicate any skin conditions you currently have or have previously experienced:

☐ Dry or flaky skin	☐ Oedema (swelling)	☐ Psoriasis	☐ Eczema/Dermatitis
☐ Easily bruised	☐ Pressure Injuries	☐ Rashes or itching	☐ Cellulitis
☐ Varicose veins	☐ Lymphedema	☐ Ulcers	☐ Skin cancer

Are you currently taking Anticoagulant / Blood-Thinning Medication	☐ Yes	☐ No
Do you currently have any wounds or skin conditions?	☐ Yes	☐ No

If yes, please specify the type, location, and current treatment below:

Type of wound / condition	Location	Current treatment

Sensory Function and Limitations

Do you have any sensory limitations or changes in any of the following areas?
Please tick all that apply and provide further details if known.

Area	Yes	No	**Details** (e.g. aids used, recent changes, or specialist involved)
Vision (e.g. glasses, cataracts, macular degeneration)	☐	☐	
Hearing (e.g. hearing aids, cochlear implant, hearing loss)	☐	☐	
Speech or communication	☐	☐	
Taste or smell	☐	☐	
Touch or sensation (e.g. neuropathy, sensitivity)	☐	☐	
Other	☐	☐	

Continence history *(Including urinary and bowel function)*

Please indicate any conditions you currently have or have previously experienced:

Urinary function

☐ Urinary incontinence	☐ Urinary retention	☐ Indwelling catheter (IDC)
☐ Suprapubic catheter (SPC)	☐ Recurrent urinary tract infections (UTIs)	
☐ Other (please specify)		

Bowel function

☐ Bowel incontinence	☐ History of constipation	☐ Diverticular disease
☐ Chronic diarrhoea	☐ Bowel obstruction	☐ Bowel cancer
☐ Other (please specify)		

Bowel routine

How regularly do you open your bowels	☐ Daily	☐ Every 2nd day	☐ Every 3rd day
☐ Other (please specify)			
Do you regularly take aperients (laxatives)		☐ Yes	☐ No
If yes, specify name & frequency			

Diet and nutrition

Do you have a diagnosed swallowing disorder?	☐ Yes	☐ No

If yes, please provide more information (e.g. texture-modified diet, thickened fluids, speech pathology):

Additional Dietary Information

☐ Vegetarian	☐ Vegan	☐ Gluten free
☐ Lactose free / dairy free	☐ Diabetic diet	☐ Low salt
☐ Other diet (please specify)		

Are there any foods that you particularly like or dislike?	☐ Yes (list below)	☐ No

Likes		Dislikes	

Rest and sleep patterns

Do you take medication to assist with sleep?	☐ Yes	☐ No
If yes, specify name & frequency		
Average hours of sleep per night		
Do you generally sleep well throughout the night?	☐ Yes	☐ No
If no, provide more information		
Do you usually rest or nap during the day?	☐ Yes	☐ No
If yes, indicate time and duration		

Pain

Please describe any painful areas, movements, or conditions, and what you have found makes the pain better or worse:

How is your pain currently managed?

☐ Regular medication	☐ PRN (as needed)	☐ Heat / cold packs	☐ Massage
☐ Other (please specify			

Other health and life experiences

Are there any other issues impacting your health that you would like to tell us about? *(e.g. recent illness, surgery, pain, mobility challenges, mental health, or other concerns)*

Are there any other life experiences that may shape your needs and the care we provide to you that you wish to tell us about? *(e.g. personal history, trauma, grief or loss, cultural or family experiences, or anything that helps us understand you better)*

Your religious, spiritual and cultural information

Please indicate your religion, spirituality, or cultural background and any associated preferences:

Are there any cultural, religious, or spiritual practices that are important for your daily life or wellbeing? *If yes, please describe:* ☐ Yes ☐ No

Would you like to remain in contact with any cultural, religious, or community organisations? *If yes, provide details (e.g. name of organisation, contact person, preferred frequency of contact):* ☐ Yes ☐ No

Do you have any specific dietary, privacy, gender, or care preferences related to your religion or culture that we should be aware of? *If yes, please specify:* ☐ Yes ☐ No

Your advance care planning & end of life wishes

Advance care plan		
Do you have an Advance Care Directive (ACD), Advance Care Plan, or other formal document outlining your wishes for future health care?	☐ Yes	☐ No
If yes, please provide details below and attach a copy for your clinical record.		
Type of document:	☐ Advance Care Directive *(legal document)*	☐ Advance Care Plan *(preferences statement)*
☐	Copy of relevant document/s attached	

End of life wishes	
Comfort and environment - *At the end of my life I would like:*	
☐ To have my family / loved ones with me	☐ Quiet surroundings
☐ Soft music / favourite sounds playing	☐ Dimmed lighting / ☐ Natural lighting
☐ My favourite blanket or personal items nearby	☐ Fresh air / window open if possible
☐ Someone to sit quietly with me (even if I'm asleep or unresponsive)	☐ Access to spiritual or religious rituals that bring me peace
☐ Other (please specify)	
Things that make me feel comforted or calm:	

People I Wish to Be Involved

I would like the following people to be informed or present when I am nearing the end of life:

Name	Relationship	Contact Number

Religious, Spiritual or Cultural Wishes

Please describe any rituals, prayers, readings, or customs that are meaningful to you at the time of death or afterwards:

Would you like your faith representative contacted if your death is imminent?	☐ Yes	☐ No
If yes, Name / Organisation		

After death preferences		
☐ Burial	☐ Cremation	☐ No preference
Funeral Director (if known)		
Address		
Contact number/s		
Special customs or requests after death *(e.g. clothing, rituals, viewing, family presence, cultural or spiritual practices)*		
Your wishes will be respected in accordance with applicable legislation and discussed with your representative and family at the appropriate time		

Accommodation Bond and Estate Details *(To assist with the refunding of your accommodation bond, if applicable)*				
Do you have a solicitor handling your estate?			☐ Yes	☐ No
If yes, does your solicitor hold a current copy of your Will?			☐ Yes	☐ No
Law firm name				
Solicitor name/s				
Address				
Phone no		Email		
Executor / Next of Kin responsible for estate administration:				
Name				
Relationship				
Phone no		Email		
Address				
Information provided will be treated confidentially and used only to assist in the lawful refund of refundable accommodation deposits and related estate matters				

Personal Information Use Consent Form

Name of resident	

Minchinbury Manor is authorised to collect, use, and disclose certain personal information in accordance with Aged Care legislation for the purposes of:

- protecting and enhancing the safety, health, wellbeing and quality of life of people accessing of aged care services
- promoting the provision of quality care and services
- developing and promoting best practice models for engagement between our organisation and the individuals we support
- dealing with complaints and incidents and/or
- regulating and monitoring the provision of aged care services.

Minchinbury Manor is committed to protecting the privacy of your personal information in compliance with the Privacy Act 1988 and as such, will not use it for any purpose other than:

- that which you give us permission for
- required by law
- required to provide safe and quality care and services and/or
- as outlined under the Australian Privacy Principles.

I,		(Please provide full name of resident or authorised representative)			
of		(please provide current residential address)			
Street number		Street name			
Suburb		State		Postcode	

consent to my information being collected and recorded for the purpose of providing care and services and the provider's duty of care.

I understand that my personal information will be shared with workers, other service providers, health professionals, advocates, government departments, my identified supporters and others as required and reasonably expected in order to provide care and services, as well as required by law.

I consent for information about my care and services to be discussed with my identified Supporters as per the table below.

Full Name of Supporter	Relationship of Supporter to the Older Person	Information which can be shared	Information which should not be shared

I do not consent for any information to be shared with the following:

Insert names or details below, or NA if not applicable

I understand that:

- I may revoke consent at any time
- I have rights to access and update my information as well as to make complaints about how my information is managed without retribution
- my provider may be obligated to disclose my information without consent if:
  - if there is a serious threat to life, health or safety of any individual or public health and safety, including locating a missing person
  - it would unreasonably infringe the privacy of other individuals
  - the information relates to legal proceedings or is in some way illegal
- I will be informed about any data breaches which may result in serious harm.

Name of resident			
Signature		Date	D D M M Y Y Y Y
Authorised representative name (if applicable)			
Relationship to the resident:			
Signature		Date	D D M M Y Y Y Y

Authority to Consent Form

Name of Resident	

Consent to activities, treatments and use of information

Please indicate whether you (or your authorised representative) consent to the following.
You may withhold consent from any item; you may also change or withdraw consent later.

Activity / Purpose	Consent		Notes / Conditions (if any)
Medical Treatment (clinical care, tests, procedures)	☐ Yes	☐ No	
Dental Treatment	☐ Yes	☐ No	
Excursions / Off-site outings	☐ Yes	☐ No	
Outdoor Activities (within facility grounds)	☐ Yes	☐ No	
Hairdressing / Beauty Therapy	☐ Yes	☐ No	
Photographs for identification / clinical purposes (e.g. wounds, medications)	☐ Yes	☐ No	
Photographs for activities / social / promotional purposes	☐ Yes	☐ No	
Name displayed outside room / suite	☐ Yes	☐ No	
Inclusion of anonymised data in National Aged Care Quality Indicator program reporting*	☐ Yes	☐ No	

I understand that:

- I (or my authorised representative) may withdraw or vary any of the consents given above at any time.
- Any new requests or changes will be documented and communicated to relevant staff.

If I am not the resident, I am completing this form in my capacity as the resident's:

☐ Guardian	☐ Spouse / Partner	☐ Enduring Power of Attorney
☐ NSW Trustee & Guardian	☐ Primary Carer (prior to admission)	☐ Relative (over 18 years of age)
☐ Other (please specify)		

Name of resident			
Signature		Date	D D M M Y Y Y Y
Authorised representative name (if applicable)			
Signature		Date	D D M M Y Y Y Y

National Aged Care Quality Indicator program reporting* - for more information refer to National Aged Care Mandatory Quality Indicator Program (QI Program) – Information sheet for older people and their Families

Responsibility for Fees Form

Name of resident			
Person responsible for payment of fees / charges			
I,		(Please provide full name)	
am the person responsible to consent to any financial matters pertaining to the above mentioned. This includes ensuring prompt payment of all accounts submitted by Minchinbury Manor Pty Ltd in connection with daily fees and other charges on behalf of the consumer (resident).			
If I am not the resident, I am completing this form in my capacity as the resident's:			
☐ Guardian	☐ Spouse / Partner	☐ Enduring Power of Attorney	
☐ NSW Trustee & Guardian	☐ Primary Carer (prior to admission)	☐ Relative (over 18 years of age)	
☐ Other (please specify)			
Signature of resident / representative		Date	D D M M Y Y Y Y
Title	☐ Mr	☐ Mrs	☐ Ms ☐ Other
Surname			
Given Name(s)			
Relationship			
Current residential address			
Street number		Street name	
Suburb		State	Postcode
Phone (Day)		Phone (Night)	
Mobile		Email	

Income and Assets Assessment

Some aged care fees are determined by Services Australia or the Department of Veterans' Affairs based on the resident's income and assets. If you have not already received an Income and Assets Determination Letter, you may need to complete the relevant Services Australia or DVA assessment process.

Please provide a copy of your Income and Assets Determination Letter once received. If this assessment has not been completed, you may be charged the applicable maximum fees until an assessment outcome is provided.

Direct Debit Request (DDR) Form

Request and Authority to debit

Facility	Entity Name	ABN	AUDE
Minchinbury Manor	Australasian Accommodation Aged Care Pty Ltd	25 094 277 862	251850

Your Surname or company name	
Your Given names or ABN/ARBN	

"You" means the person, persons, company or entity named above who is authorised to operate the nominated account.
I / we request and authorise Australasian Accommodation Aged Care Pty Ltd, Direct Entry User ID / AUDE 251850, to arrange a debit to my / our nominated account to pay for residential aged care fees and charges relating to the resident named above at Minchinbury Manor.
This debit or charge will be arranged by Australasian Accommodation Aged Care Pty Ltd's financial institution and made through the Bulk Electronic Clearing System Framework (BECS) from your nominated account and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.

Amount of debit
The amount specified in the monthly statement, invoice, account notice or other written notice issued to you for amounts payable in relation to residential aged care fees and charges, for payment on the due date.
Unless otherwise agreed in writing, debits will occur monthly on the 10th day of each month. The first debit will occur on the next scheduled monthly debit date after this authority has been processed.

Account to be debited

Name/s on account			
Financial Institution name			
Financial Institution branch			
BSB number (must be 6 digits)		**Account number**	

Your contact details

Address			
Email		**Phone**	

Confirmation
By signing and/or providing us with a valid instruction in respect of this Direct Debit Request you confirm that:

- you are authorised to operate the nominated account;
- you authorise Australasian Accommodation Aged Care Pty Ltd, Direct Entry User ID / AUDE 251850, to debit your nominated account in accordance with this Direct Debit Request;
- you have understood and agreed to the terms and conditions set out in this Request and in your Direct Debit Request Service Agreement; and
- direct debiting may not be available on all accounts and you should check with your financial institution if unsure.

Signature 1		**Date**	D D M M Y Y Y Y
Signature 2 (if required)		**Date**	D D M M Y Y Y Y

If debiting from a joint bank account, both account holders must sign where required by the account authority.

Direct Debit Request Service Agreement

This is your Direct Debit Request Service Agreement with **Australasian Accommodation Aged Care Pty Ltd ABN 25 094 277 862, Direct Entry User ID / AUDE 251850** (the Debit User). It explains your obligations when undertaking a Direct Debit arrangement with us. It also details our obligations to you as your Direct Debit provider.

Please keep this agreement for future reference. It forms part of the terms and conditions of your Direct Debit Request and should be read in conjunction with your Direct Debit Request authorisation.

Definitions

account	means the account held at your financial institution from which we are authorised to arrange for funds to be debited.
agreement	means this Direct Debit Request Service Agreement between you and us.
banking day	means a day other than a Saturday, Sunday or public holiday.
debit day	means the day that payment by you to us is due.
Direct Debit Request	means the written, verbal or online request between us and you to debit funds from your account.
us or we	means Australasian Accommodation Aged Care Pty Ltd, the Debit User you have authorised.
you	means the person, persons, company or entity who has authorised the Direct Debit Request.
your financial institution	means the financial institution at which you hold the account you have authorised us to debit.

1. Debiting your account
1.1 By submitting a Direct Debit Request, you have authorised us to arrange for funds to be debited from your account. The Direct Debit Request and this agreement set out the terms of the arrangement between us and you.
1.2 We will only arrange for funds to be debited from your account as authorised in the Direct Debit Request, or where we have issued a monthly statement, invoice, account notice or other written notice specifying the amount payable by you to us and when it is due.
1.3 If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you are unsure about which day your account has been or will be debited, you should ask your financial institution.

2. Amendments by us
2.1 We may vary any details of this agreement or a Direct Debit Request at any time by giving you at least 30 days written notice sent to the preferred email or address you have given us in the Direct Debit Request.

3. How to cancel or change direct debits
You can cancel or suspend the Direct Debit Request, or change, stop or defer an individual debit payment, at any time by giving us at least 7 working days' notice before the next scheduled debit date.
To do so, contact us on 02 9832 5800 (option 4) during business hours or by email at accounts@aaacare.com.au. You can also contact your own financial institution, which must act promptly on your instructions.

4. Your obligations
4.1 It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the Direct Debit Request.
4.2 If there are insufficient clear funds in your account to meet a debit payment, you may be charged a fee and/or interest by your financial institution; we may charge you reasonable costs incurred by us; and you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be available by an agreed time.
4.3 You should check your account statement to verify that the amounts debited from your account are correct.

5. Accounts
You should check with your financial institution whether direct debiting is available from your account, as direct debiting is not available on all accounts.
You should check that the account details you have provided to us are correct by checking them against a recent account statement, and check with your financial institution before completing the Direct Debit Request if you have any queries.

6. Dispute
If you believe there has been an error in debiting your account, you should notify us directly on 02 9832 5800 (option 4) during business hours or by email at accounts@aaacare.com.au. Alternatively, you can contact your financial institution for assistance.
If we conclude that your account has been incorrectly debited, we will arrange within a reasonable period for your account to be adjusted or the amount refunded. If we conclude that your account has not been incorrectly debited, we will provide you with reasons for this finding.

7. Confidentiality
We will keep any information, including your account details, in your Direct Debit Request confidential. We will make reasonable efforts to keep such information secure and to ensure that our employees or agents do not make unauthorised use, modification, reproduction or disclosure of that information.
We will only disclose information to the extent specifically required by law, for the purposes of this agreement, to our financial institution or sponsor bank to initiate or manage the drawing to your nominated account, or in connection with any query, claim or dispute.

8. Contacting each other
If you wish to notify us in writing about anything relating to this agreement, contact the Accounts Team by email at accounts@aaacare.com.au or by phone on 02 9832 5800 (option 4).
We will notify you by sending a notice to the preferred email or postal address you have given us in the Direct Debit Request. Any notice will be deemed to have been received on the second banking day after sending.

Initial terms of the arrangement
In terms of the Direct Debit Request arrangements made between *us* and signed by *you*, *we* undertake to periodically debit *your* nominated account for the agreed amount for Residential Aged Care Fees and charges, as notified to you through your monthly statement or other written notice.

Alternative Payment Option — EFT / Bank Transfer

If you do not wish to set up a Direct Debit Request, payment may be made by electronic funds transfer using the details below.

Please ensure the resident's name or account/customer code is included as the payment reference.

Payment Method	EFT / Bank Transfer
Account name	Australasian Accommodation Aged Care Pty Ltd
Bank	Westpac
BSB	032 102
Account number	377614
Payment reference	Resident surname and/or account/customer code

Please note: EFT payments are not direct debit payments. EFT payments must be initiated by you through your own internet banking or financial institution.

Office use only

Field	Details
Date received	
Received by	
Entered into billing system	☐ Yes ☐ No
Date entered	
Entered by	
DDR checked against resident account	☐ Yes ☐ No
Notes	