Elderly Services

3, *Ċentru Servizz Anzjan*, Old Mint Street, Valletta, VLT 1510
E-mail: aaccd-services@gov.mt
Website: www.activeageing.gov.mt
Telephone: 22788800

* *Indicates mandatory information*

Section 1: Applicant's Details

Name:* _____

Surname:* _____

Identity Card Number:* _____

Address:* _____

Locality:* _____

Post Code: _____

Gender:* ☐ Male ☐ Female ☐ Other

Date of Birth:* (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

Telephone Number: _____

Mobile Number: _____

E-mail: _____

Entitlement Number: _____

Special Identity Card: _____

Pink Form: Valid From _ _ / _ _ / _ _ _ _ Valid To _ _ / _ _ / _ _ _ _

Yellow Card *(for those suffering from diabetes)* ☐ Y ☐ N

Civil Status:*

☐ Married
☐ Widow/er ☐ Separated ☐ Civil Union
☐ Single ☐ Divorced ☐ Cohabitation

Nationality:* ☐ Maltese ☐ EU ☐ Other (Name Country of Origin) _____

Section 2: Next of Kin Details

	1st Next of Kin	2nd Next of Kin	3rd Next of Kin
Name & Surname of your Next of Kin:			
Identity Card Number:			
Relation to Applicant:			
Contact Number:			
E-mail:			
Power of Attorney or Person of Trust:			

Section 3: Please tick (✓) which service you require

Kindly read carefully

Services which are marked with the note "**Medical Report Required**" indicate that in order to apply, ***Section 4 – Medical Report*** of this application must be completed by your family doctor and endorsed with an official stamp and his/her signature respectively.

	Reference	Service		Reference	Service
☐	1	Active Ageing Centres	☐	11	Carer at Home Scheme
☐	2	Home Help Service (Medical Report Required)	☐	12	Dementia Activity Centre (Medical Report Required)
☐	3	Respite at Home (Medical Report Required)	☐	13	Social Work
☐	4	Respite (Medical Report Required)	☐	14	Night Shelter (Medical Report Required)
☐	5	Handyman Service	☐	15	Home Admission (Medical Report Required)
☐	6	Telecare+	☐	16	Be Active – Gozo
☐	7	Telephone Rent Rebate (Pink Form Required)	☐	17	Podiatry Service
☐	8	Meals on Wheels (Medical Report Required)	☐	18	Physiotherapy Service
☐	9	Continence Service (Medical Report Required)	☐	19	Occupational Therapy Service
☐	10a	Domiciliary Nursing (Medical Report Required)	☐	20	Community Geriatrician
☐	10b	Domiciliary Caring (Medical Report Required)			

For Respite Service, please indicate the period required in the table below:

Reference	Service	From	To
4	Respite – Malta		
4	Respite – Gozo		
3	Respite at Home		

For Active Ageing Centres (Reference 1), please indicate Locality: _____

☐ *Any other Service/s which you may require, but which is/are not listed above*

_____

_____

Kindly provide a reason why the Service/s selected is/are being requested

_____

_____

_____

Section 4: Medical Report *(To be filled by a Doctor as applicable)*

1. **Medical History & Diagnosis**

2. **Communication Abilities**

3. **Pyschological State**

☐ Fully Oriented ☐ Occasionally Confused ☐ Confused ☐ Disoriented

4. **Behavioural State**

☐ Good ☐ Apathetic ☐ Aggressive ☐ Wandering

5. **ADLs (Activities of Daily Living)**

	Independent	Assisted	Dependent
Feeding	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Mobility	☐	☐	☐

6. **List of Medications**

7. **Social Situation**

The applicant: ☐ Lives Alone ☐ Lives with Someone Else ☐ Sapport Social Network

8. **Domiciliary Allied Health Intervention**

Applicable only for the frail, vulnerable and those who cannot exit own homes. ☐ Yes ☐ No

9. **Other Relevant Information** *(include other clinics / services used)*

Name & Surname *(Doctor)*

Medical Council Number

Signature *(Doctor)*

Contact No. *(Doctor)*

Date

Rubber Stamp

Section 5: Declaration

I understand that as stipulated by the Data Protection Act (Cap. 440.), upon making a written request, I will have the right to know which information is being held about me by the Department. I also understand that for the purpose of the same Act, the personal data controller is:

Department of Active Ageing and Community Care
Bugeja Institute – 469, St. Joseph High Road,
St. Venera, SVR 1012 Malta

I confirm that I have read/was read this declaration and understood it entirely.

This application and attached information will remain valid for six months from date of receipt.

Name & Surname of Applicant in Block Letters _____

Signature of Applicant _____

Identity Card _____

Date _____

--------- For Official Use Only ---------

Name & Surname in Block Letters of employee receiving application _____

Signature of person receiving application _____

Other remarks _____

Date _____