ADMISSION TO HOMES FOR THE ELDERLY

Dear Sir / Madam,

Kindly note that this application should be filled accordingly:

Pages 2, 3, 8 and 9    By the applicant or person assisting
Pages 4, 5, 6 and 7    By your General Practitioner

Applications should be sent to the following address:

Ċentru Servizz Anzjan
3, Old Mint Street,
Valletta

Tel: 2557 5105

Thank you
APPLICATION: FIRST PART

A. DETAILS OF APPLICANT

Name and Surname: __________________________________________
Maiden Surname: ____________________________________________ Identity Card Number: __________________________
Address: __________________________________________________
__________________________________________________________ Post Code: __________________________
Date of Birth: ______________________________________________
Telephone Number: _________________________________________ Mobile: __________________________
Status: □ Single □ Married
□ Widow / Widower □ Separated

Mark your preference starting with number 1 as your first choice and indicate other preferences in descending order:

Preferenza: □ Saint Vincent de Paul □ Cospicua
□ Floriana □ Zammit Clapp
□ Mosta □ Msida
□ Mtarfa □ Żejtun
□ Mellieha

B. DETAILS CONCERNING FAMILY OF APPLICANT:

In case where applicant is a married male,
Include wife’s name and maiden surname: __________________________

In case where applicant is a married female, her husband’s name: __________________________

Name and surname of next of kin or agent: __________________________
Address: ______________________________________________________
__________________________________________________________ Post Code: __________________________
Telephone Number: __________________________________________ Mobile: __________________________
In the case of a next of kin, indicate relationship: __________________________
C. DECLARATION BY THE APPLICANT:

I declare that the details supplied by myself in this application or as read to me are correct.

I understand that if this application is approved and I refuse admission to the residence indicated, a fresh application would have to be submitted for reconsideration;

Signature of Applicant

Signature of person making declaration
(in the case where the request has not been submitted by the applicant)

Name and Surname of person making declaration: 
Address: 
Post Code: 
Identity Card Number: Relationship to Applicant: 

Signed / declared in my presence

Date: 
Doctor’s Signature:
Medical Council Number:
APPLICATION PART TWO  TO BE COMPLETED BY A MEDICAL DOCTOR

1. Applicant’s Personal Data:

Name and Surname: __________________________________________________________
Maiden Surname: ________________  Identity Card Number: _______________________
Date of Birth: ________________  Age: _________  Weight: ________

2. Medical History and Diagnosis:  ____________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. Drug Treatment:  __________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

4. Communication Abilities:  Good  Fair  Poor  Absolute Loss
   Hearing
   Speech
   Vision

- 4 -
5. Mental State:

Orientated (Time, Place and Person)  
- Always  
- Occasionally  
- Rarely/Never

Memory  
- Well Preserved  
- Impaired  
- Poor

Hallucinations / Delusions  
- 

Paranoid Ideas  
- 

Behavioural State  
- Good  
- Apathetic  
- Aggressive

Substance Abuse  
- Specify: 

6. Daily Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Performs the activity</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dressing</td>
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<td></td>
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<tr>
<td>Bathing</td>
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<tr>
<td>Housekeeping</td>
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<td></td>
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<tr>
<td>Meal Preparation</td>
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<td></td>
<td></td>
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<tr>
<td>Shopping</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. **Mobility:**
- [ ] Walks long distances unaided
- [ ] Walks short distances unaided
- [ ] Walks with a walking aid
- [ ] Walks with physical assistance
- [ ] Gets in and out of bed without help
- [ ] Gets in and out of bed with help
- [ ] Wheelchair/armchair bound
- [ ] Bedridden

8. **Continence:**
- [ ] Goes to the toilet without aid
- [ ] Goes to the toilet with aid
- [ ] Uses a bed-side commode/bed-pan
- [ ] Has a urinary catheter/penile sheath
- [ ] Incontinent/occasionally incontinent of urine
- [ ] Incontinent/occasionally incontinent of faeces
- [ ] Colostomy

9. **Need for nursing care**
- [ ] Minimal/simple custodial care
- [ ] Primary nursing care
- [ ] Close medical care and supervision
- [ ] Drug Administration
- [ ] Care of personal hygiene
- [ ] NG Tube
- [ ] Peg feeding
- [ ] Liquidised
- [ ] Semi solids
- [ ] Skin care (e.g. Pressure areas)
- [ ] Bladder/Bowel care
- [ ] Special needs (specify)
10. **Social State**

   Lives alone:
   
   [ ] Always   [ ] Occasionally   [ ] Never

   *If the applicant lives always or occasionally alone, give the following details:*

   Sleeps alone:
   
   [ ] Always   [ ] Occasionally   [ ] Never

   Receives visits:
   
   [ ] Less than one visit per week   [ ] Daily / frequent visits

   Who are the carers?
   
   [ ] Relatives   [ ] Friends / Neighbours   [ ] Community / hired help   [ ] No carers

11. **Reasons why the applicant is unable to continue living in the community:**

   [ ] Deterioration of physical / mental condition   [ ] Feeling Lonely

   [ ] Does not want to be burden on others   [ ] Unable to cope alone

   [ ] House unsuitable to meet the applicant’s needs   [ ] Carers cannot cope

   [ ] House in poor condition   [ ] Homeless

12. **If the Applicant is presently hospitalised, state:**

   Where: ________________________________________________________________

   Ward: ___________________________       Consultant: ___________________________
13. Other remarks: 

Date: ___________________________ Doctor’s Signature: ___________________________
Name in BLOCK LETTERS: ___________________________
Telephone Number: ___________________________ Mobile: ___________________________
Address: ___________________________
Post Code: __________________________
Medical Council Number: ___________________________

14. Management of applicant’s remaining social security benefits or pension whilst in St. Vincent de Paul Residence / Home for the Elderly

Please Tick your preferred option with an ‘X’
If ‘Option 1’ is already in practice, you are kindly advised to ignore this notice.
Both application forms, for Options 1 and 2 can be obtained from all Social Security Branches.

☐ Option 1: Deposit in an Applicant’s “Savings” Bank Account and Electronic Notification. (Not Applicable in cases of Social Assistance or Non-contributory pension, i.e. Age Pension).
If this option is chosen, this form needs to be duly filled and handed in to any one of the Social Security branches. If this is not done prior admission to St. Vincent de Paul Residence or a Home for the elderly, regularisation MUST be done on admission. In such an instance, the Applicant is to contact Officer in charge of Government Home, or the Contributions Office if admitted at St Vincent de Paul residence.

☐ Option 2: Application to consent Department of Social Security and send Social Security benefits / pension cheques to an authorised person.
To be filled once admitted to St. Vincent de Paul Residence or a Home for the Elderly.
STATEMENT OF CONSENT

I hereby give my consent to the Department for the Elderly and Community Care to process and record personal and sensitive data being given herewith in order to be able to render the service I am applying for.

I fully understand that:

By opting out, my application cannot be processed
Authorised personnel who are processing this information may have access to this data in order to supply me with the service being applied for.
Edited information, that would not identify me, may be included in statistical reports

I know that I am entitled to see the information, related to me, should I ask for it in writing.

I am aware that for the purposes of the Data Protection Act, the Data Controller is:

Department for the Elderly and Community Care
469 St Joseph High Road
Santa Venera CMR 02

☐ I have read and understood this statement of consent myself
☐ This statement of consent was read and explained to me

Signature: ________________________  Signature: ________________________
(Data Applicant)                  (Reader, if applicable)
ID Number: ________________________ ID Number: ________________________
Date: ____________________________