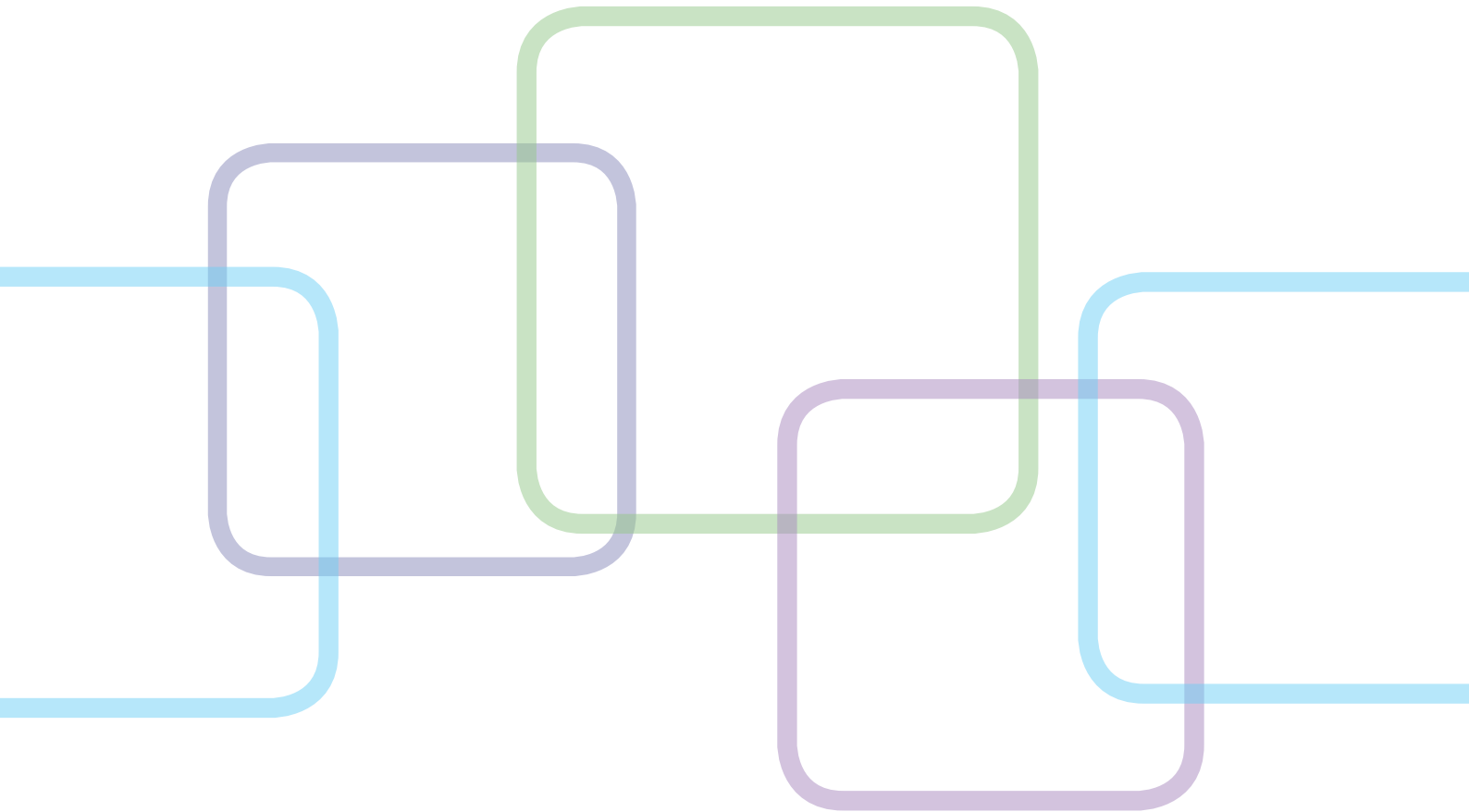


MAURICE ZEFFERT HOME (INC)

ADMISSIONS DOCUMENTATION

Please complete all enclosed documentation and return
for admission to the wait list for residency



Maurice Zeffert Home (Inc)

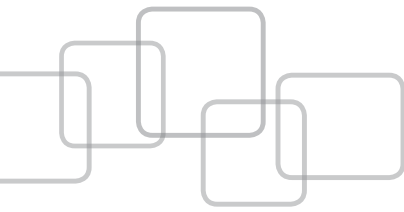
CHECK LIST

HAVE YOU COMPLETED:

- APPLICATION FORM
- MEDICAL EVALUATION FORM
- RESIDENT SOCIAL PROFILE
- COPHARMACY – ADMISSION NOTIFICATION
- COPHARMACY – DIRECT DEBIT REQUEST (DDR)
- PRIVACY CONSENT FORM
- ENDURING AUTHORITY TO PUBLISH
- DIRECT DEBIT REQUEST
- OPTION NOT TO PROVIDE

HAVE YOU INCLUDED:

- 1) A copy of ACCR (Aged Care Client Record) completed by Aged Care Assessment Team
- 2) A copy of Enduring Power of Attorney/ Power of Attorney
- 3) A copy of Power of Guardianship
- 4) A copy of Centrelink/ DVA Income and Asset Assessment Notice



MAURICE ZEFFERT HOME (INC)

David, Gita and Michael Hoffman Nursing Home
Toby and Maurice Zeffert Special Care Centre
Carl and Sadie Cohen Hostel
Sir Zelman and Lady Cowan Retirement Village
Sydney Crownson-Cohen Home Units

119 Cresswell Road, Dianella WA 6059
Phone 9375 4600 Fax 9276 1250
Email: info@mzh.org.au

APPLICATION FORM

PERMANENT **RESPITE** (FOR ADMISSION INTO RESIDENTIAL AGED CARE)
PLEASE TICK: HIGH CARE HOSTEL KEREN OR (DEMENTIA SPECIFIC)

SECTION 1

SURNAME: _____

PREFERRED NAME (TO BE CALLED BY): _____ LEGAL GIVEN NAMES: _____

HEBREW NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

DO YOU: OWN RENT BOARD OTHER

PHONE (HOME): _____ PHONE (MOBILE): _____

COUNTRY OF BIRTH: _____ DATE OF ARRIVAL IN AUSTRALIA: _____

NATURALISED: YES NO NATIONALITY: _____

RELIGION: JEWISH - ORTHODOX JEWISH-LIBERAL OTHER

FIRST LANGUAGE: _____ OTHER LANGUAGES SPOKEN: _____

MARITAL STATUS: SINGLE DE FACTO DIVORCED MARRIED WIDOWED SEPARATED

FATHER'S GIVEN AND SURNAME: _____

FATHER'S HEBREW NAME: _____

MOTHER'S GIVEN AND MAIDEN NAME: _____

MOTHER'S HEBREW NAME: _____

SECTION 2

PENSION/MEDICAL INSURANCE DETAILS FULL PART

CENTERLINK NO: _____ MEDICARE NO: _____ EXPIRY DATE: _____

VETERANS AFFAIRS NO: _____ CARD TYPE - GOLD WHITE EXPIRY DATE: _____

PHARMACY SAFETY NET ENTITLEMENT CARD NO: _____

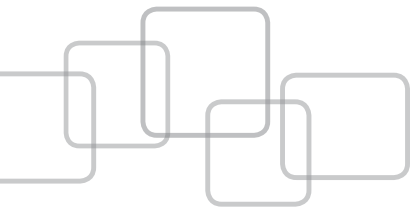
PHARMACY SAFETY NET CONCESSION CARD NO: _____

REPATRIATION FILE NO: _____

PRIVATE HEALTH INSURANCE FUND (NAME): _____

MEMBERSHIP NO: _____ EXPIRY DATE: _____

AMBULANCE SUBSCRIPTION NO: _____ EXPIRY DATE: _____



APPLICATION FORM

SECTION 3

POWER OF ATTORNEY

HAVE YOU APPOINTED A POWER OF ATTORNEY: YES NO

ENDURING POWER OF ATTORNEY: YES NO

IF YES, PLEASE PROVIDE THE FOLLOWING DETAILS:

NAME OF PERSON HOLDING POWER OF ATTORNEY:

ADDRESS:

TELEPHONE NO:

MOBILE NO:

EMAIL:

PLEASE PROVIDE A COPY OF THE POWER OF ATTORNEY DOCUMENTATION

SECTION 4

GUARDIANSHIP

HAVE YOU APPOINTED A GUARDIANSHIP AUTHORITY: YES NO

IF YES, PLEASE PROVIDE THE FOLLOWING DETAILS:

NAME OF PERSON HOLDING GUARDIANSHIP AUTHORITY:

ADDRESS:

TELEPHONE NO:

MOBILE NO:

EMAIL:

PLEASE PROVIDE A COPY OF THE POWER OF GUARDIANSHIP DOCUMENTATION

SECTION 5

NEXT-OF-KIN (SPOUSE, CHILDREN OR NEAR RELATIVES) (WHO WILL BE CONTACTED UPON SERIOUS ILLNESS OR SUDDEN DEATH)

STATE FULL NAME, ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS

1. NAME: RELATIONSHIP:

NAME OF PERSON HOLDING GUARDIANSHIP AUTHORITY:

ADDRESS:

PHONE HOME :

PHONE WORK :

MOBILE NO :

EMAIL :

2. NAME: RELATIONSHIP:

NAME OF PERSON HOLDING GUARDIANSHIP AUTHORITY:

ADDRESS:

PHONE HOME :

PHONE WORK :

MOBILE NO :

EMAIL :

NAME AND ADDRESS OF PERSON BILLING ACCOUNT WILL BE SENT TO

NAME:

ADDRESS:

PHONE HOME :

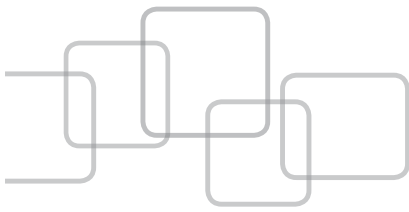
PHONE WORK :

MOBILE NO :

EMAIL :

APPLICANT'S SIGNATURE:

DATE:



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Phone 9375 4600 Fax 9276 1250
Email: info@mzh.org.au

MEDICAL EVALUATION FORM

TO BE COMPLETED BY MEDICAL PHYSICIAN

APPLICANT'S SURNAME: _____ FIRST NAMES: _____

CURRENT ADDRESS: _____

PHONE: _____ DATE OF BIRTH: _____

NAME AND ADDRESS OF DOCTOR COMPLETING FORM: _____

PHONE: _____ LENGTH OF TIME HE/SHE HAS BEEN A PATIENT: _____

REASON FOR SEEKING ADMISSION: _____

MAJOR CURRENT MEDICAL PROBLEMS: _____

MAJOR OTHER DIAGNOSED PROBLEMS: _____

HOSPITALISATION: _____

HOSPITAL: _____ CONSULTANT: _____

CONDITION TREATED: _____ DATE: _____

1. _____

2. _____

3. _____

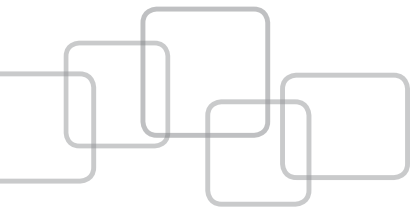
IS APPLICANT CURRENTLY ATTENDING OUTPATIENTS CLINICS OR SPECIALISTS? YES NO

IF YES, WHICH ONES? _____

HAS APPLICANT BEEN ASSESSED BY AN AGED CARE ASSESSMENT TEAM (ACAT)? YES NO

IF YES, WHICH ONES? _____

(Please attach photocopies of Discharge Summaries/Letters/Assessments)



MAURICE ZEFFERT HOME (INC)

MEDICAL EVALUATION FORM

SYSTEMS REVIEW PLEASE PROVIDE DIAGNOSIS AND BRIEF SUMMARIES OF HISTORY

RESPIRATORY

RELEVANT DETAILS:

DATE OF LAST CHEST X-RAY AND FINDINGS:

PAST SMOKER: YES NO STILL SMOKES: YES NO HISTORY OF TB: YES NO

PNEUMOCOCCAL VACCINE GIVEN: YES NO YEAR:

FLUVAX GIVEN: YES NO DATE:

CARDIOVASCULAR

RELEVANT DETAILS:

PULSE: B.P.: ANY POSTURAL CHANGE:

PERIPHERAL PULSES:

E.C.G.

PACEMAKER YES NO IF YES, BEING MONITORED BY:

GASTROINTESTINAL

RELEVANT DETAILS:

APERIENT USAGE: FAECAL INCONTINENCE YES NO

DENTITION:

ENDOCRINE

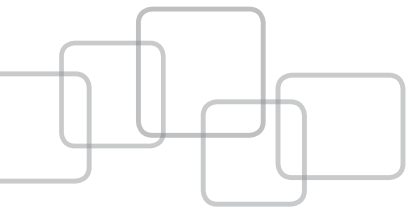
RELEVANT DETAILS:

HAEMOPOIETIC

RELEVANT DETAILS:

SKIN

RELEVANT DETAILS:



SYSTEMS REVIEW PLEASE PROVIDE DIAGNOSIS AND BRIEF SUMMARIES OF HISTORY

GENITOURINARY

RELEVANT DETAILS:

INCONTINENCE YES NO

CAUSE, IF KNOWN:

MUSCULOSKELETAL

RELEVANT DETAILS:

NEUROLOGICAL

RELEVANT DETAILS:

HAS APPLICANT SUFFERED STROKE(S)? YES NO

DETAILS (COPY OF CT REPORT WOULD BE HELPFUL):

DESCRIBE DEGREE OF DISABILITY:

DOES APPLICANT SUFFER FROM HEADACHES/FITS/FALLS/DIZZINESS/VERTIGO? YES NO

DETAILS:

VISION

RELEVANT HISTORY/DIAGNOSIS:

OPHTHALMOLOGIST/OPTOMETRIST NAME:

DATE LAST SEEN (APPROX):

SPECTACLES YES NO

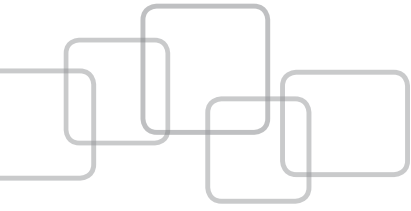
HEARING

RELEVANT HISTORY/DIAGNOSIS:

ENT SPECIALIST/AUDIOLOGIST NAME:

DATE LAST SEEN (APPROX):

HEARING AID YES NO



MEDICAL EVALUATION FORM

MENTAL STATE AND PSYCHIATRIC HISTORY

PAST HISTORY OF PSYCHIATRIC ILLNESS YES NO

DETAILS:

IS APPLICANT FULLY ALERT AND WELL ORIENTED? YES NO

POSSIBLE OR DEFINITE DEMENTIA PRESENT? YES NO

LIKELY CAUSE OF DEMENTIA: ALZHEIMER TYPE/MULTI-INFARCT/OTHER:

(SPECIFY):

MEMORY/INTELLECTUAL DECLINE FIRST NOTED: DATE

BEHAVIOURAL PROBLEMS OR WANDERING? YES NO

DETAILS:

DEMENTIA INVESTIGATED? YES NO

DETAILS (PLEASE INCLUDE CT AND OTHER INVESTIGATIONS AND RESULTS):

CURRENT MEDICATIONS

MENTAL STATE AND PSYCHIATRIC HISTORY

DRUG SENSITIVITY/ADVERSE DRUG REACTIONS:

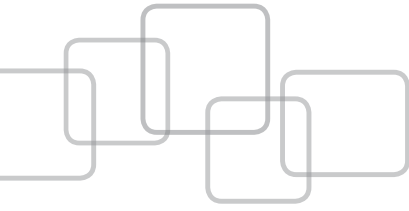
OTHER RECENT OR RELEVANT INVESTIGATIONS AND REPORTS

PHOTOCOPIES OF KEY RESULTS AND REPORTS WOULD BE APPRECIATED

OTHER DETAILS ABOUT THE APPLICANT'S CONDITION WHICH YOU CONSIDER IMPORTANT (INCLUDE INFECTIONS WITH HIGH RISK OF TRANSMISSION IN THE HEALTH CARE SETTING)

SIGNED

DATED



MAURICE ZEFFERT HOME (INC)

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RESIDENT SOCIAL PROFILE

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

The information will be used to develop an individualised activity program and support to meet the residents needs

RESIDENT NAME:

DATE:

ACTIVITY PREFERENCES (ON ENTRY TO THE HOME):

PLEASE IDENTIFY (✓) THOSE ACTIVITIES THAT WOULD OR HAVE BEEN OF INTEREST

<input type="checkbox"/> INDOOR BOWLS	<input type="checkbox"/> SYNAGOGUE
<input type="checkbox"/> COMMUNITY SINGING/CHOIR	<input type="checkbox"/> GROUP DISCUSSIONS
<input type="checkbox"/> NEWSPAPER READINGS	<input type="checkbox"/> OUTINGS
<input type="checkbox"/> EXERCISE TO MUSIC	<input type="checkbox"/> COOKING
<input type="checkbox"/> WORD GAMES/QUIZZES	<input type="checkbox"/> CONCERTS/PERFORMANCES
<input type="checkbox"/> CARDS	<input type="checkbox"/> VIDEO/FILMS
<input type="checkbox"/> FLORAL ART	<input type="checkbox"/> CRAFT
<input type="checkbox"/> PARLOUR GAMES	<input type="checkbox"/> JIGSAWS
<input type="checkbox"/> BINGO	<input type="checkbox"/> BEAUTY CARE
<input type="checkbox"/> ART	<input type="checkbox"/> HAPPY HOUR
<input type="checkbox"/> GARDENING	<input type="checkbox"/> CROSSWORDS
<input type="checkbox"/> GUIDED WALKS	<input type="checkbox"/> OTHER (PLEASE SPECIFY)

IS THE RESIDENT ON THE ELECTORAL ROLL? YES NO

IF YES, CURRENT ELECTORATE:

DO YOU WISH THE RESIDENT TO REMAIN ON THE ELECTORAL ROLL? YES NO

It is the responsibility of the primary carer to change the electoral district. To remove the resident from the electoral role you will require a letter from the medical practitioner.

SPIRITUAL AND CULTURAL DETAILS

DURING THEIR LIFE, HAS THE RESIDENT ATTENDED SYNAGOGUE REGULARLY? YES NO

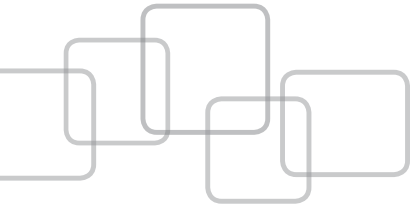
WOULD THE RESIDENT LIKE TO ATTEND SYNAGOGUE AT MAURICE ZEFFERT HOME? YES NO

ANY SPECIFIC CULTURAL PREFERENCES:

E.G. DIET:

FESTIVALS OBSERVED:

CULTURAL PREFERENCES/ PRACTICES (EG, CLOTHING/ SOCIAL CONTACT/ RITUALS):



LIFE PROFILE

CHILDHOOD

LIVED AT:

EDUCATION:

ADULT YEARS

LIVED AT:

EDUCATION:

WORK:

LEISURE INTERESTS:

RETIREMENT

LIVED AT:

LEISURE INTERESTS:

LIST ANY SIGNIFICANT LIFE EXPERIENCES (EG, AWARDS, DISASTERS, ACHIEVEMENTS):

TRAVEL EXPERIENCE:

HOLOCAUST AND WARTIME EXPERIENCES:

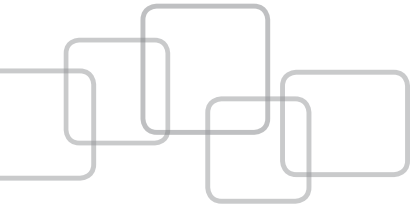
SIGNIFICANT EVENTS AND DATES:

WEDDING ANNIVERSARY:

CHILDREN'S BIRTHDAYS:

DEATH OF SIGNIFICANT OTHER:

OTHER:



RESIDENT SOCIAL PROFILE

LIFE PROFILE

FAVOURITES AND FEARS

PREFERRED FOOD:

DRINK:

FLOWER(S):

COLOUR:

ANIMAL:

BOOKS/MAGAZINES/MOVIES:

MILITARY ROMANTIC THRILLER COMEDY LIFESTYLE WESTERNS

CURRENT AFFAIRS GARDENING HOBBIES/CRAFT SPORT OTHER (PLEASE SPECIFY):

MUSIC:

CLASSICAL COUNTRY ROCK 'N' ROLL JAZZ MUSICALS

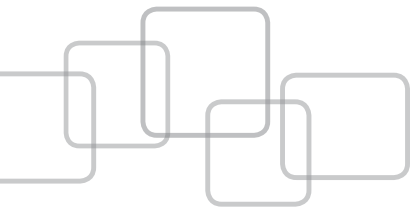
"OLD TIME" OTHER (PLEASE SPECIFY):

RADIO PROGRAMS:

TELEVISION PROGRAMS:

SPORT:

FEARS/DISLIKES (EG, DARK, HEIGHTS, ANIMALS, BEACH ETC):



MAURICE ZEFFERT HOME (INC)

RESIDENT SOCIAL PROFILE

LIFE PROFILE

FAMILY AND SOCIAL NETWORK:

FAMILY AND/OR FRIENDS LIKELY TO BE INVOLVED WITH RESIDENT:

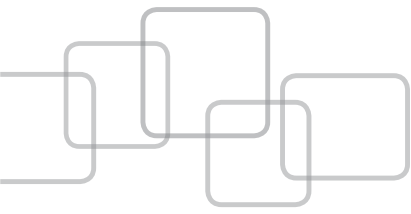
ASSOCIATIONS/VOLUNTARY ORGANISATIONS THAT RESIDENT IS/HAS BEEN INVOLVED IN:

PETS:

NAME(S) OF SIBLINGS:

NAME(S) OF CHILDREN:

NAME(S) OF GRANDCHILDREN:



MAURICE ZEFFERT HOME (INC)

Maurice Zeffert Home has an arrangement with Co-Pharmacy who provide a full pharmaceutical service. Medication costs are billed directly to the resident by the pharmacy

CO-PHARMACY RESIDENT/RELATIVE INFORMATION

ADMISSION AND DISCHARGE:

- Upon Admission CoPharmacy ask for the following information-
 - “CoPharmacy Admission form” is completed for each Resident. Please ensure ALL fields are completed. This information is required before CoPharmacy can provide all medication safely, at the correct cost and as soon as possible.
 - A complete list of medication signed by doctor
 - All current prescriptions (especially Authority Prescriptions).
 - Safety Net details.
 - Prescription Record Form (PRF) for previous pharmacy.
- Unfortunately medication previously supplied from other pharmacies especially multi-dose packs (Webster) can not be used by CoPharmacy. Unfortunately we cannot ensure the safety and integrity of the medication once dispensed and stored.
- If residents are discharged from a facility, Copharmacy can organise for medications and prescriptions to be delivered to a facility prior to discharge or they are welcomed to be collected from our office. Please note CoPharmacy does require accounts to be paid in full.

DISPENSING:

- CoPharmacy dispenses government subsidised medication according to the Pharmaceutical Benefit Scheme (PBS). More information on the PBS can be found at <http://www.pbs.gov.au/html/home>
- The PBS Safety Net plays an important role in keeping medications affordable. It is an effective way of helping limit the out of pocket expenses for people who require a large amount of medications. The Safety Net runs from January 1st to December 31st each year. Each January prescription fees will revert back to the standard PBS prescription cost until the safety net is reached again.
- Safety Net thresholds (general)= \$1,421.20
Concession holders= \$360.00 (60 prescriptions)
- Safety net totals for couples. If your spouse uses another pharmacy, it is important to notify CoPharmacy on what prescriptions have been obtained as their total will be combined with yours, reach the safety net sooner.
- Doctors are required to supply CoPharmacy with prescriptions in a timely manner. In the rare cases this does not happen it may be necessary to reprice those items as private items due to the fact that the PBS denies subsidy. The repricing of the item does not alter the legal requirement of the Doctor to provide the paper prescription.
- In the very rare cases where supply may be interrupted due to prescription not being supplied by Resident Doctor CoPharmacy will always notify Facility Managers.
- If resident is going on Social Leave or Holidays, we can provide medications in advance. Please advise facility with adequate notice to arrange supply.
- Non prescription items – You may hear of these items being on sale or at a lower price than Copharmacy in supermarkets and other pharmacies. CoPharmacy strives to ensure all our products are at the most affordable prices possible whilst also keeping the price consistent to avoid confusion with accounts. Often these sale prices at supermarkets and pharmacies are only for a small time period, they then increase to prices well above the CoPharmacy consistent price. CoPharmacy also delivers to

facilities directly, provide medication trolleys to facilities and offer an after hours service that is not offered at other pharmacies or supermarkets.

MEDICATION CHANGES:

- Doctors often change medications. When this occurs they will inform the pharmacy of the urgency of the medication change, “Urgent next dose”, “within 24hrs” or “with next weekly pack”. Those medications that are initiated with the following week sachets reduce the amount of medication wastage and impact on the account.
- All regular packed medications are in the form of a sachet. Unfortunately sachets can not be reused or re packed, all replacing medications need to be re-dispensed.
- Medications that have not all been used and stopped due to a doctor making changes unfortunately can not be returned and credited.

OWING PRESCRIPTIONS:

- An Owing prescription is a name given to an item that CoPharmacy dispenses in good faith awaiting a paper prescription being provided by the resident Doctor. These orders are often communicated to Copharmacy via fax or phone order so they can be supplied promptly.
- Paper prescriptions are a legal requirement. If a doctor does not provide a paper prescription with the exact date the medication was supplied as “owing”, pharmacy must re-dispense the item. This will then appear on the account on the date dispensed rather than the date the medication was supplied. This may result in a multiple charge for the same item appearing on one month's account, however as above the item may have been supplied earlier (potentially in the month prior). If you have any queries our accounts department are more than happy to help.

ACCOUNTS:

- CoPharmacy offers an account to all residents. The account does have a strict 30 day credit policy. Accounts are required to be paid in full each month to ensure continuous supply.
- Accounts are sent out monthly and can be paid via credit card, direct debit, EFT, cheque, postal order or pay by cash at CoPharmacy. Payments via electronic (direct debit, credit card or EFT) are preferred as they are instant and will reflect on your account immediately unlike cash payments. Electronic payments can be setup by contacting our Accounts Department.
- Account can be kept in credit if so that payments may be infrequent yet still receiving monthly accounts.
- CoPharmacy do reserve the right to apply an Account Management (collection) Fee and in extreme cases where requests for payments have been ignored, in collaboration with Facility Managers, may suspend services until the account is made current.

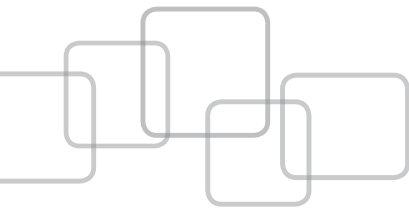
CONTACTS:

Accounts Manager-

Phone 9AM-3PM: (08) 9333 0106 OR (08) 93330108

Email: accounts@copharmacy.com.au

Mail: Accounts Department, 101 Norma Rd, Myaree, WA 6154



MAURICE ZEFFERT HOME (INC)

CO-PHARMACY

ADMISSION NOTIFICATION

PLEASE PRINT INFORMATION CLEARLY. WHERE APPLICABLE, PLEASE TICK (✓) THE APPROPRIATE BOX.

RESPITE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES UNTIL	/	/
FACILITY:	WARD/AREA:			
PATIENT NAME:	ROOM NUMBER:			
SURNAME	CHRISTIAN NAME/S			
DOCTOR:	DATE OF BIRTH:			
ALLERGIES:	PHONE NUMBER:			

PHARMACEUTICAL BENEFITS DETAILS Please tick (✓) appropriate box after sighting entitlement card. Note this must be complete for the correct entitlement and charging of patient medications.

<input type="checkbox"/> PENSION / CONCESSION	<input type="checkbox"/> REPAT (GOLD)	<input type="checkbox"/> REPAT (WHITE)	
<input type="checkbox"/> ENTITLEMENT (SAFETY NET)	<input type="checkbox"/> NONE		
PBS ENTITLEMENT NO.	EXPIRY DATE	/	/

MEDICARE BENEFITS DETAILS Please provide an attached photocopy of the Medicare card

MEDICARE CARD NUMBER - - - (Note: the final digit refers to the Patient Ref. No. on Card)

EXPIRY DATE / /

PREVIOUS PHARMACY NAME

PRIVATE HEALTH COVER

To claim the gap on some pharmaceuticals resident must phone and confirm membership number and eligibility. Receipts for private scripts will be printed on request.

MEDICATION REVIEWS

As part of our pharmacy service, an accredited pharmacist may find this patient eligible for a comprehensive medication management review. Report findings are sent to their Doctor and Facility.

Does the patient consent to this? YES NO

PERSON RESPONSIBLE FOR ACCOUNT PAYMENT

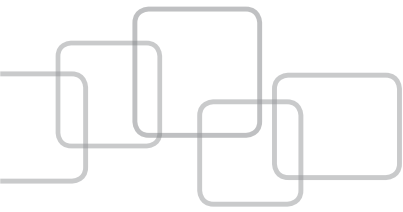
NAME:

SURNAME: CHRISTIAN NAME/S:

POSTAL ADDRESS:

CONTACT PHONE NUMBER:

I _____ (Patient / Agent) declare that all information provided within this document to be true to the best of my knowledge. Should the provided information be incomplete or insufficient I authorise CoPharmacy to contact Medicare or relevant authorities to obtain the required information.



MAURICE ZEFFERT HOME (INC)

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CO-PHARMACY DIRECT DEBIT REQUEST (DDR)

CUSTOMER'S AUTHORITY:

NAME OF CUSTOMER/S GIVING THE DDR:

I/WE:

NAME OF DEBIT USER:

AUTHORISE AND REQUEST YOU **CO-PHARMACY MYAREE** APCA USER ID NUMBER 303956

to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System or to debit my/our account by any other means.

CLIENT'S NAME:

HOUSE NAME:

COPHARMACY ACCOUNT NUMBER:

This authorisation is to remain in force in accordance with the terms described in the Direct Debit Service Agreement.

CUSTOMER'S ADDRESS

RESIDENTIAL ADDRESS:

POSTCODE:

PHONE NUMBER: ()

DETAILS OF THE ACCOUNT TO BE DEBITED

NAME AND ADDRESS OF THE FINANCIAL INSTITUTION AT WHICH YOUR ACCOUNT IS HELD

POSTCODE:

ACCOUNT NAME (please insert your name in full):

BSB NUMBER:

ACCOUNT NUMBER:

ABN/ARBN (if applicable)

BRANCH NAME :

DECLARATION (If in joint name/s both signatures may be required)

I/WE ALSO AUTHORISE THE FOLLOWING:

1. The Debit user to verify the details of the abovementioned account with my/our financial institution
2. The financial institution to release information allowing the Debit User to verify the abovementioned account details.

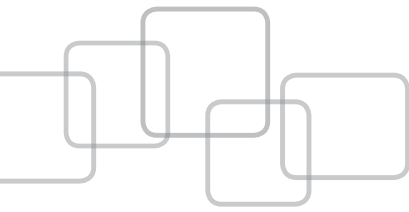
SIGNATURE

DATE

SIGNATURE

DATE

Please Note Direct Debiting is not available on the full range of accounts, if in doubt please refer to your financial institution.



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CO-PHARMACY DIRECT DEBIT REQUEST (DDR)

Please ensure that you have read the following before sending in the Direct Debit Request. Please retain this page for your records.

- * We may vary this agreement at any time giving you at least 14 days notice
- * By signing a Direct Debit Request, you request us to arrange for funds to be debited from your account according to the agreement we have with you. The amounts drawn will be as due under your account with us.
- * We will arrange for funds to be debited to your account.

a) as requested and authorised in the Direct Debit Request; and/or

b) according to any notice sent to you specifying the amount payable and the date the payment is due.

The payment will be deducted from your nominated account on the 21st day of the month following the issue of your statement. If the payment date falls on a non-working day or public holiday, the payment will be processed on the next working day.

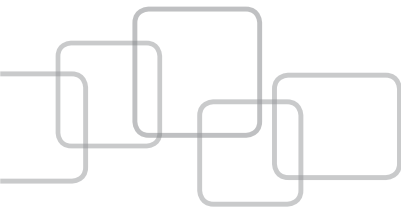
- * It is your responsibility to ensure that you have sufficient funds in the nominated account(s) when the payments are to be drawn. If you do not have sufficient funds, the transaction will be rejected and a dishonour fee may be charged to your account. We treat the payment as if it were never made.
- * You should be aware that :

a) Direct Debiting through Bulk Electronic Clearing System is not available on all accounts

b) Account details should be checked against a recent statement from your financial institution. If you are in doubt, you should check with your financial institution before completing the Direct Debit Request; and

c) it is your responsibility to advise us if your nominated account is altered, transferred or closed

- * If you believe there has been an error in debiting your account you should contact us on (08) 9333 0106 during business hours as soon as possible so that we can resolve your query quickly
- * Your records and account details will be kept private and confidential and will only be disclosed at your request or at the request of the financial institution in connection with a claim made to an alleged incorrect or wrongful debit, or otherwise as required by law.
- * For all matters relating to the Direct Debit arrangement on your account, including requests for deferment of debits, alteration of debit arrangements or stopping or cancelling your Direct Debit request, please call us on (08) 9333 0106 between 9am - 3pm, Monday to Friday.



MAURICE ZEFFERT HOME (INC)

David, Gita and Michael Hoffman Nursing Home
Toby and Maurice Zeffert Special Care Centre
Carl and Sadie Cohen Hostel
Sir Zelman and Lady Cowan Retirement Village
Sydney Crownson-Cohen Home Units

119 Cresswell Road, Dianella WA 6059
Phone 9375 4600 Fax 9276 1250
Email: info@mzh.org.au

PRIVACY CONSENT FORM

The Maurice Zeffert Home (Inc) requires your authorisation in order to collect your personal information.

Your consent is to protect your rights and prevent confidential information breaches.

The Maurice Zeffert Home (Inc) Privacy Statement and Policy explains the circumstances and conditions of your consent. Further information and explanation is available on request.

I _____ HEREBY AUTHORISE THE COLLECTION OF PERSONAL INFORMATION
ABOUT _____

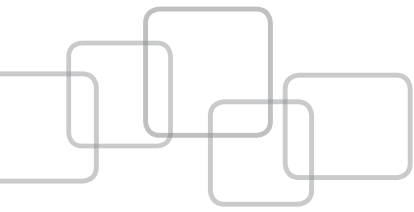
- I have received the Privacy Statement and Policy and have been given opportunity to ask questions.
- My questions have been answered to my satisfaction.
- I understand that I can ask further questions at any time.

RELATIONSHIP TO RESIDENT

RESIDENT NAME: _____ OR _____ POWER OF ATTORNEY NAME: _____

RESIDENT SIGNATURE _____ OR _____ POWER OF ATTORNEY NAME: _____

DATE: _____



MAURICE ZEFFERT HOME (INC)

PRIVACY STATEMENT

Maurice Zeffert Home acknowledges and respects the privacy of individuals. We support and are committed to complying with the Australian Privacy Principles and Guidelines endorsed by the Office of the Australian Information Commissioner.

Any personal information we collect about you will only be used for the purposes we have collected it or as allowed under the law.

Types of Information

When we refer to personal information, this can broadly be defined as information that identifies your person. This can include demographic information such as full name, date of birth and address. It can also include sensitive information that may refer to matters relating to health (such as health history, health practitioners, social circumstances, next of kin details; or matters relating to finances (Centrelink or DVA assessments, direct debit details).

Government Related Identifiers

If we collect government identifiers, such as your tax file number or Medicare number, we do not use or disclose this information other than authorised by law.

Why we Collect your Personal Information

We collect personal information for the purposes of:

- Providing quality health or aged care services to you;
- Administering and managing those services;
- Managing our relationship as an approved provider with you as a consumer;
- Assisting your treating health professionals or carers in providing care to you at our facilities or in the community;
- Internal administrative requirements, including information required by our insurers, legal representatives, and bodies related to accreditation; and
- Developing our services through quality review such as clinical audit, planning, and evaluation.

We do not collect your personal information for the purposes of direct marketing and will not offer you other products and services outside the scope of our purpose as an approved provider of residential care, day therapy, or retirement living.

How do we Collect your Personal Information?

Wherever possible and practicable we will collect personal information directly from you and your family/responsible person. This may happen before admission to our services; at admission; and ongoing while you receive residential care, day therapy, or retirement living provided by us.

We may also collect personal information from health professionals, government departments and agencies, or your family/responsible person. We may also collect information from bona fide third parties who provide services to you.

Why Maurice Zeffert Home may Disclose your Personal Information

For sole purpose of providing quality services to you, there will be times when we will need to disclose your personal information to third parties. These third parties may include:

- Health professionals;
- Our service contractors where such information is essential for provision of care and services;
- State and Commonwealth departments; and
- Your representatives including family, responsible persons, guardians or administrators.

Before any disclosure of personal information to another person or organisation, Maurice Zeffert Home will take all reasonable steps to satisfy our needs that:

- The other person or organisation has a commitment to protecting your personal information which as a minimum is equal to our policy; or
- You have consented to us making the disclosure.

All information that we have stored is on our IT server and offsite and not stored outside Australia.

Marketing

We will not provide your information to third parties for direct marketing. However, we may use your information to provide you with current

information about our services (including new services being offered by us), changes to our organisation, or any benefits that we are made aware of that in good faith we believe may be a benefit to you as a person.

If you do not wish to receive such information, you may at anytime decline to receive such by telephoning us on (08) 9375 4600, by emailing us at info@mzh.org.au, or by writing to us at 119 Cresswell Road Dianella 6059. We are committed to take all reasonable steps to meet your request at the earliest possible opportunity.

Updating Your Personal Information

It is important that any personal information we hold about you is accurate and up to date. During our relationship of providing services or accommodation, we may ask you to inform us if any of your personal information has changed. We may ask you to inform us of any errors relating to personal information and to keep us informed of any changes relating to personal information.

You may contact us at any time if you wish to make changes to your personal information, as we may rely on you to ensure the information we hold is accurate and/or complete.

Access to Personal Information

We are committed to providing you with access to personal information we hold about you at any time and we will take all reasonable steps to respond within five working days. We aim to respond immediately where we can, however we may need to contact other people or organisations to properly respond to your request.

Please note that we are not required to provide you with access to your personal information in certain circumstances. These include where the information relates to existing or reasonably anticipated legal proceedings or if such request is vexatious. If access is denied, you will be informed why that has occurred.

Correction of Personal Information

If any of the personal information we hold about you is incorrect, inaccurate or out of date you should request that we correct the information. Where possible, we will correct the personal information immediately, although we may require five working days where we need to consult other people or organisations to properly respond to your request.

If for any reason we refuse to correct personal information, you will be informed as to our reasons for not correcting the information.

Safety and Security of Personal Information Held

We may store your personal information in paper and electronic form. Maurice Zeffert Home takes reasonable steps to protect your personal information by storing it in a secure environment. We also ensure we take reasonable steps to protect any personal information from misuse, loss and unauthorised access, modification or disclosure.

Complaints and Feedback

All service users have a right to complain about the service they are receiving without fear of retribution, and can expect complaints to be dealt with fairly, promptly and confidentially by Management.

If you are dissatisfied with how we have dealt with your personal information, you may contact our Chief Executive Officer on (08) 9375 4600, by emailing info@mzh.org.au or by writing to:

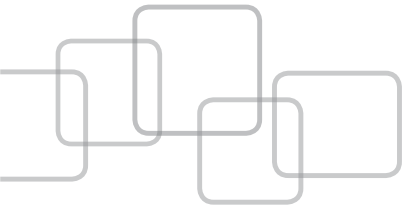
119 Cresswell Road Dianella WA 6059.

Maurice Zeffert Home will acknowledge your complaint within seven days and provide a decision or feedback on your complaint within 30 days.

If you are dissatisfied with our internal response, you may make a complaint to the Privacy Commissioner who can be contacted via the Office of the Australian Information Commissioner website (www.oaic.gov.au) or on 1300 363 992.

Further Information

You may request further information about the way we manage your personal information by contacting us.



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ENDURING AUTHORITY TO PUBLISH

I _____ GIVE MY PERMISSION FOR PHOTOS OF _____

attending activities at the Maurice Zeffert Home (Inc) and information and photos in the resident profiles to be used for MZH internal documents, the Maccabean, other Jewish publications and on the Home's website.

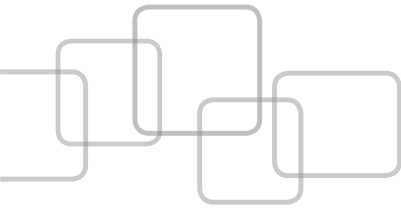
If there are any changes to be made to this enduring authority, I will notify the Executive Care Manager in writing.

SIGNED _____

DATE _____

RELATIONSHIP TO RESIDENT _____

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DIRECT DEBIT REQUEST

CUSTOMERS' AUTHORITY:

NAME OF CUSTOMER(S) GIVING THE DDR:

I/WE:

APCA USER ID NUMBER 301500

AUTHORISE YOU MAURICE ZEFFERT HOME (INC):

to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System (BECS).

This authorisation is to remain in force in accordance with the terms described in the **RESIDENTIAL CARE AGREEMENT**

SIGNATURE:

DATE: / /

SIGNATURE:

DATE: / /

DETAILS OF THE ACCOUNT TO BE DEBITED (ALL DETAILS MUST BE SUPPLIED)

NAME OF THE FINANCIAL INSTITUTION:

BRANCH NAME:

ACCOUNT NAME:

BSB NUMBER:

ACCOUNT NUMBER:

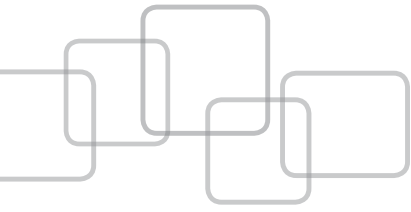
PAYMENT DETAILS

THE PAYMENT IS FOR **RESIDENTIAL CARE FEES PER MONTHLY ACCOUNT**

IDENTIFIED BY NUMBER:

PLEASE TICK I/WE REQUEST THAT YOU DEBIT MY/OUR ACCOUNT IN ACCORDANCE WITH OUR AGREEMENT

(RESIDENTIAL CARE AGREEMENT AND MONTHLY ACCOUNT)



MAURICE ZEFFERT HOME (INC)

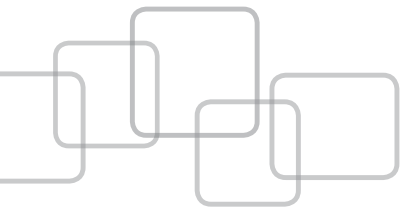
DIRECT DEBIT REQUEST

DIRECT DEBIT REQUEST SERVICE AGREEMENT

1. The Customer will be advised 14 days in advance of any changes to the Direct Debit arrangements;
 2. For all matters relating to the Direct Debit arrangements, the Customer will need to send written correspondence to the address 119 Cresswell Road, Dianella WA 6059 outlining the request/issue and allow for 14 days for the amendments to take effect.
 3. The Customer should be aware that:
 - a Direct debiting through BECS is not available on all accounts; and
 - b Account details should be checked against a recent statement from its Financial Institution.
If you are in any doubt, you should check with your Financial Institution before completing the drawing authority.
 4. It is your responsibility to ensure sufficient cleared funds are in the nominated debiting account when the payments are to be drawn.
 5. If the due date for payment falls on a non-working day or public holiday, the payment will be processed on the previous working day. If the Customer is in any doubt, please refer to the Point 3 for further clarifications.
 6. For returned unpaid transactions, the following procedures or policy will apply:
We shall proceed to reapply for the funds one week later.
 7. Fees and charges:
Any fees incurred from the bank for unpaid transactions will be reclaimed from your account.
 8. All Customer records and account details will be kept private and confidential to be disclosed only on the request of the Customer or Financial Institution in connection with a claim made to an alleged incorrect or wrongful debit.
- I/We authorise the following:
1. The Debit User to verify the details of the abovementioned account with my/our Financial Institution
 2. The Financial Institution to release information allowing the Debit User to verify the abovementioned account details.

SIGNED BY THE CUSTOMER(S)

DATED / /



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OPTION NOT TO PROVIDE

CENTRELINK OR DEPARTMENT OF VETERANS' AFFAIRS (DVA) INCOME AND ASSET ASSESSMENT

The Aged Care Act (1997) permits aged care facilities to charge accommodation payments providing an individual is left with a minimum of 2.5 times the annual Australian aged pension.

Centrelink or the Department of Veterans' Affairs (DVA) will assess a resident's income and assets on behalf of the Department of Health and Ageing, even if the resident does not receive a pension.

Having an Income and Assets Assessment is not compulsory. However, it is a requirement of entry to Maurice Zeffert Home (Inc) that either a Centrelink or DVA Income and Assets Assessment or the "Option Not to Provide" is provided at the time of application.

By electing to complete the "Option Not to Provide" you are confirming that you have sufficient funds to be charged the maximum Residential Fees including the maximum Accommodation Payment and Means Tested Care Fees.

I (FULL NAME):

CONFIRM THAT I DO NOT WISH TO PROVIDE AN INCOME AND ASSET ASSESSMENT FROM CENTRELINK OR DEPARTMENT OF VETERANS' AFFAIRS (DVA).

I understand that by choosing not to undertake an income and assets assessment I am not eligible to receive government assistance with accommodation costs and that I will pay the maximum rate of accommodation payments and means tested care fees.

APPLICANT OR *POA SIGNATURE:

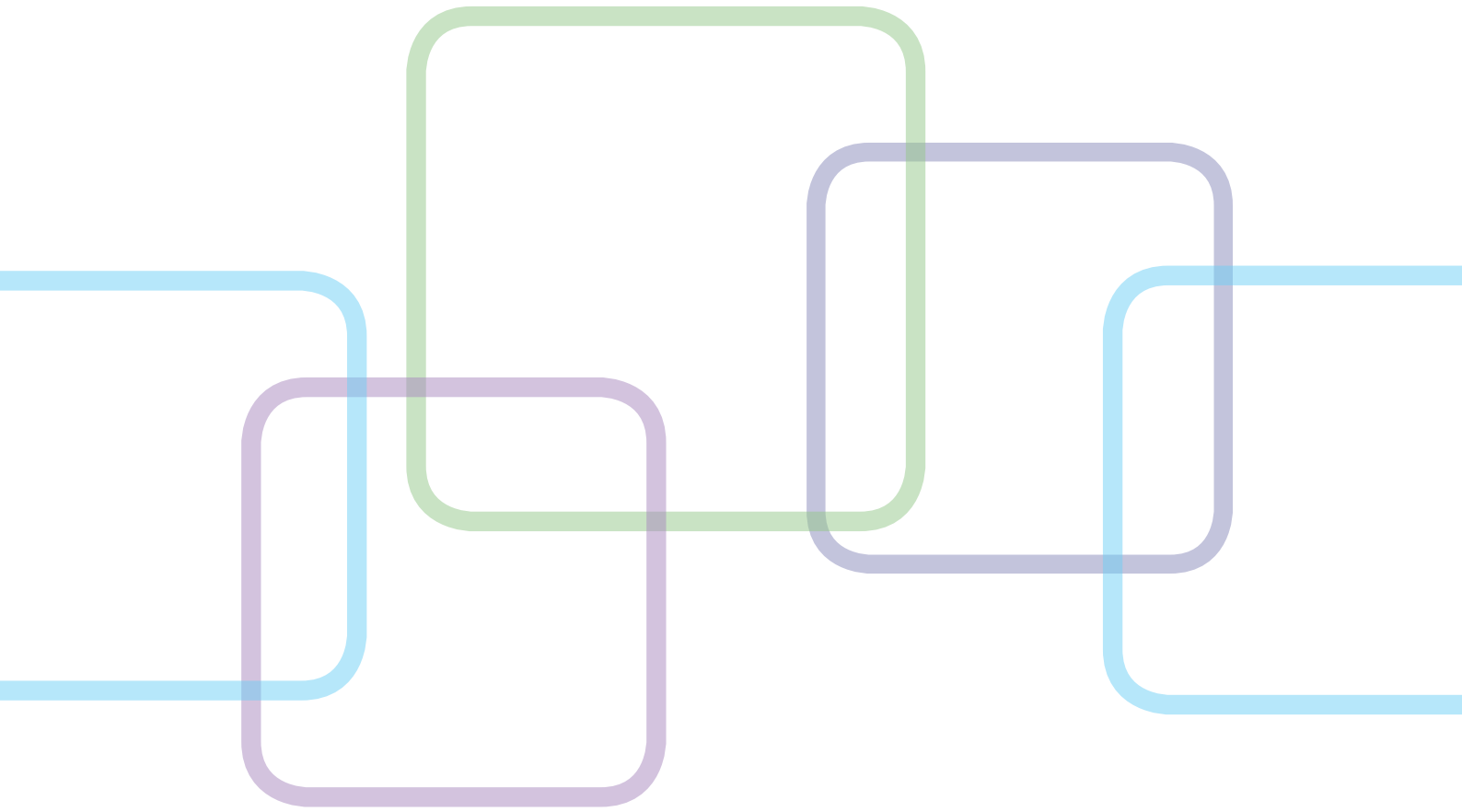
DATE: / /

APPLICANT ADDRESS:

POST CODE:

* If signing under Power of Attorney please ensure a copy of Power Of Attorney or Enduring Power Of Attorney is provided

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MAURICE ZEFFERT HOME (INC)

www.mzh.org.au