Australian Government

myagedcare

APPLICATION FOR EMERGENCY
RESIDENTIAL CARE UNDER
THE *AGED CARE ACT 2024*

PRIVACY

The use and/or disclosure of information collected in the course of assessing care needs and/or deciding whether to approve a person as a care recipient to access one or more types of Commonwealth subsidised aged care is authorised by Sections 537 to 540 of the *Aged Care Act 2024.*

EMERGENCY APPLICATION FOR ACCESS TO FUNDED AGED CARE SERVICES

Complete this form if the person urgently needed the care when it started and it was not practicable to apply for approval beforehand.

Print the name of the individual requiring care (exactly as it appears on the individual's Medicare card or DVA concession card).

I am applying to undergo an aged care needs assessment. Before I have been assessed I have received the type(s) of aged care I have ticked below. (Tick at least one box).

Residential care ☐

Residential respite care ☐

Note that if the needs assessor decides that you are eligible to receive a type of aged care, this does not mean that you must agree to receive that type of care.

Date

Signature

This form should be signed by the applicant or someone authorised to do so on their behalf. Only in exceptional circumstances should someone else sign. If this is the case, please COMPLETE the following:

Why was the applicant unable to sign?

Name of person who did sign (please print)

Relationship to the applicant
(eg Guardian, Power of Attorney, Spouse, GP, Solicitor, etc)

Unit No./No. Street Suburb/Town

Postcode State/Territory Phone

Blank

To be completed by the service provider

EMERGENCY	The person urgently needed the care when it started, and it was not practicable to apply for approval beforehand.	Yes ☐
If YES, reason for emergency approval must be included in the comments relating to "Current Support" in the Integrated Assessment Tool		An application for emergency approval must be made within 5 calendar days after the day care starts, unless extended under Section 71 of the *Aged Care Act 2024*.
Approved Provider Number (mandatory if Yes)		Date care started.

Signature