Elderly Services

Uffiċċju għall-Anzjani u Persuni b'Diżabilita'
Pjazza San Franpistk
Rabat Għawdex
22156620

MINISTERU GĦAL GĦAWDEX

Section 1: Applicant's Details

Name:* _____

Surname:* _____

Identity Card Number:* _____

Address:* _____

Locality:* _____

Post Code: _____

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

Telephone Number: _____

Mobile Number: _____

E-mail: _____

Entitlement Number: _____

Special Identity Card: _____

Gender:* ' Male ' Female ' Other

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

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

Name & Surname of your Next of Kin: _____

Identity Card Number: _____

Relation to Applicant: _____

Contact Number: _____

E-mail: _____

Power of Attorney or Person of Trust: _____

Name & Surname of your 2nd Next of Kin: _____

Identity Card Number: _____

Relation to Applicant: _____

Contact Number:

E-mail: _____

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
A	Physiotherapy	I	Active Ageing Centres
B	Home Admission – Gozo (Medical Report Required)	J	Home Help Service (Medical Report Required)
C	Hairdressing		
D	Meals on Wheels	K	Handyman Service
E	Day Centre Ghajnsielem	L	University of 3rd Age
F	Continence Service (Medical Report Required)		
G	Telecare	M	Social Work
H	Telephone Rent Rebate	N	Be Active – Gozo

For Active Ageing Centres (Reference I), 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. Social Situation

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

7. Domiciliary Allied Health Intervention

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

8. Other Relevant Information

_____

_____ _____ _____

Name & Surname *(Doctor)* Medical Council Number Signature *(Doctor)*

_____

Date

Rubber Stamp

Section 5: Declaration

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

Care for the Elderly and Special Needs
Section
St Francis Square
Victoria

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

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

_____

Name & Surname in Block Letters of employee receiving application _____

Signature of person receiving application _____

Other remarks _____

Date