



Appointment of a nominee

If you are in residential aged care, you may authorise another person (a ‘nominee’) to deal with the Australian Government Department of Health and Ageing (‘the Department’) on your behalf. The nominee may receive information from the Department about your care costs and may give the Department information about your income and assets. If you decide not to appoint a nominee, the Department will contact you directly about these matters. You may vary or cancel the appointment of a nominee at any time, by writing to the Department. **Please note:** if your nominee does not hold a Power of Attorney or similar, both you and your nominee will receive letters from the Department.

Please mail the completed form to Aged Care Medicare Australia in your State/Territory**

NSW and ACT

GPO Box 9923
 SYDNEY NSW 2001

SA and NT

GPO Box 9923
 ADELAIDE SA 5001

WA

GPO Box 9923
 PERTH WA 6001

QLD

GPO Box 9923
 BRISBANE QLD 4001

VIC and TAS

GPO Box 9923
 MELBOURNE VIC 3001

**Providing aged care payments to service providers on behalf of the Department.

Part A - Resident’s personal details

Resident’s family name

Mrs/Mr/Ms/Miss

Date of birth

 / /

Given names

Health and Ageing ID (if known)

Name of Aged Care Home

Phone number

 ()

Address of Aged Care Home

Postcode

1. Is the resident *physically* impaired and cannot complete this form?

Yes → Go to Part C

No → Answer Question 2

2. Is the resident *mentally* impaired and cannot complete this form?

Yes → Go to Part D

No → Go to Part B

Part B - To be completed when the resident is without physical or mental impairment

a) Declaration - Resident

- I certify that I am voluntarily appointing a nominee.
- I authorise the Department to discuss my care costs, income and assets with my nominee.
- I authorise the Department to send letters about my care costs to my nominee.
- I understand that I can cancel this appointment at any time, by writing to the Department.

Signature of resident

Date

b) Nominee's personal details

Family name

Mrs/Mr/Ms/Miss/Dr etc

Given names

Phone number (day time)

Postal address

<input type="text"/>
Postcode

c) Declaration - Nominee

- I certify that any information I obtain from the Department or Medicare Australia will be kept confidential and will not be disclosed to any unauthorised person without permission of the person appointing me.
- I understand that I can cancel this appointment at any time, by writing to the Department.
- I understand that I must inform the Department of any changes to my address and contact details, and changes in the circumstances of the person who has appointed me.

Signature of nominee

Date

Please indicate if you hold any of the following forms of authorisation on behalf of the resident.

- | | |
|--------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> enduring power of attorney | <input type="checkbox"/> guardianship order |
| <input type="checkbox"/> financial management/administration order | <input type="checkbox"/> appointment of enduring guardian |

If so, please attach a copy of the relevant authorisation.

Need help? Call the Aged Care Information Line on 1800 500 853.

You have completed the form

Part C - To be completed when the resident is so physically impaired that they cannot complete this form

a) Nominee's personal details

Family name

Mrs/Mr/Ms/Miss/Dr etc

Given names

Phone number (day time)

Postal address

<input type="text"/>
Postcode

b) Please indicate if you hold any of the following forms of authorisation on behalf of the resident:

- | | |
|--------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> enduring power of attorney | <input type="checkbox"/> guardianship order |
| <input type="checkbox"/> financial management/administration order | <input type="checkbox"/> appointment of enduring guardian |

If so, please attach a copy of the relevant authorisation.

c) Declaration - Nominee

- I certify that any information I obtain from the Department or Medicare Australia will be kept confidential and will not be disclosed to any unauthorised person without permission of the person appointing me.
- I understand that I can cancel this appointment at any time, by writing to the Department.
- I understand that I must inform the Department of any changes to my address and contact details, and changes in the circumstances of the person who has appointed me.

Signature of nominee

Date

Please note: If you hold one of the forms of authorisation at (b) above, the resident declaration below is not required.

d) Declaration - Resident

- I certify that I am voluntarily appointing a nominee.
- I authorise the Department to discuss my care costs, income and assets with my nominee.
- I authorise the Department to send letters about my care costs to my nominee.
- I understand that I can cancel this appointment at any time, by writing to the Department.

Signed at the direction of the resident by the
Director of Nursing/Hostel Manager/Care Manager

Date

Name

Position

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You have completed the form

Part D - To be completed when the resident is to mentally impaired that they cannot complete this form

a) Nominee's personal details

Family name

Mrs/Mr/Ms/Miss/Dr etc

Given names

Phone number (day time)

Postal address

Postcode

To be appointed the nominee of a mentally impaired resident, you must be authorised to do so:

b) Do you have any of the following forms of authorisation to act on the resident's behalf?

- | | |
|--------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> enduring power of attorney | <input type="checkbox"/> guardianship order |
| <input type="checkbox"/> financial management/administration order | <input type="checkbox"/> appointment of enduring guardian |

If so, please attach a copy of the relevant authorisation

c) If you do not have one of the above forms of authorisation, are you the spouse/partner of the resident?

- Yes
 No

d) Declaration - Nominee

- I certify that any information I obtain from the Department or Medicare Australia will be kept confidential and will not be disclosed to any unauthorised person.
- I understand that I can cancel this appointment at any time, by writing to the Department.
- I understand that I must inform the Department of any changes to my address and contact details, and changes in the circumstances of the person for whom I am acting.

Signature of nominee

Date

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You have completed the form

www.health.gov.au

All information in this publication is correct as of January 2011