**Annex 1**

**Application Form for Residential / Day Respite Service for the Elderly[[1]](#footnote-1),[[2]](#footnote-2)**

**Part I：Personal Information**

1. **Particulars of Applicant:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name in Chinese: |   | Name in English: |   |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sex: |   | Native Place: |   | Religion: |   | Dialect: |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HKIC No.: |   | Date of Birth: |   | Age: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Marital Status: |   | Telephone No.: |   |

|  |  |
| --- | --- |
| Address: |   |

1. **Particulars of Caregiver (Emergency Contact):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name in Chinese: |   | Name in English: |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sex: |   | Relationship: |   | Telephone No.: |   |

|  |  |
| --- | --- |
| Address (if not living with the applicant): |   |

1. **Particulars of Family Members and Other Relatives (if yes):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Sex | Relationship with applicant | Address (if not living with the applicant) / Telephone No. |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

1. **Financial Condition:** (Please check the appropriate box(es).)

*(No need to fill out this section for applicant of day respite service.)*

|  |  |
| --- | --- |
| [ ]  | On Comprehensive Social Security Assistance(Able-bodied or 50% disabled / 100% disabled / Requiring constant attendance) \* |
| [ ]  | On Old Age Living Allowance |
| [ ]  | On Disability Allowance(Normal Disability Allowance / Higher Disability Allowance) \* |
| [ ]  | On Old Age Allowance |
| [ ]  | Others (Please specify:  |   | ) |

\* Please delete where inappropriate.

**Part II：Medical and Health Condition**

1. **Medical History:** (Please check the appropriate box(es).)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| [ ]  | Stroke | [ ]  | Hypertension | [ ]  | Heart disease | [ ]  | Dementia |
| [ ]  | Cataract | [ ]  | Diabetes | [ ]  | Renal failure | [ ]  | Physical disabilities |
| [ ]  | Cancer | [ ]  | Gout | [ ]  | Mental illness | [ ]  | Parkinson’s disease |
| [ ]  | Bone fracture | [ ]  | Osteoporosis | [ ]  | Others (please specify: |   | ) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Recent Medical Records: | [ ]  | No | [ ]  | Yes (please provide) |

1. **Other Physical Condition and Point-to-note:** (Please check the appropriate box(es).)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Speech: | [ ]  | Normal | [ ]  | Impaired / need prompting to express or difficult to express | [ ]  | Unable to express |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Vision: | [ ]  | Normal | [ ]  | Impaired / need to wear glasses | [ ]  | Blind |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Hearing: | [ ]  | Normal | [ ]  | Impaired / need to wear hearing aids | [ ]  | Deaf |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Swallowing: | [ ]  | Normal | [ ]  | Easy choking | [ ]  | Swallowing difficulties |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Mobility: | [ ]  | Independent | [ ]  | Require assistance from others | [ ]  | Bedridden / paralysed |
|  | [ ]  | Self-ambulatory with wheelchair | [ ]  | Self-ambulatory with walking aids  |
|  |  |  |  | (Please specify: |   | ) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Bladder control: | [ ]  | Normal | [ ]  | Occasional incontinence | [ ]  | Total incontinence |
| Bowel control: | [ ]  | Normal | [ ]  | Occasional incontinence | [ ]  | Total incontinence |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Meal: | [ ]  | Normal | [ ]  | Pureed | [ ]  | Minced | [ ]  | Diabetic | [ ]  | Low-purine |
|  | [ ]  | Naso-gastric tube feeding | [ ]  | Thickener required | [ ]  | Vegetarian |
|  | [ ]  | Others (please specify: |   | ) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication: | [ ]  | No | [ ]  | Yes (Please specify the name / instructions for use: |  |
|  |  |  |  |   | ) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Allergy to food or drugs: | [ ]  | No | [ ]  | Yes (Please specify: |   | ) |

|  |  |  |
| --- | --- | --- |
| Mental state (if any special circumstances, please specify): |   |  |

|  |  |  |
| --- | --- | --- |
| Other physical condition / nursing need (if any, please specify): |   |  |

1. **Activities of Daily Living / Self-care Ability:** (Please check the appropriate box(es).)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Fully Capable** | **Partially Dependent on Others** | **Totally Dependent on Others** |
| Bathing | [ ]  | [ ]  | [ ]  |
| Washing face / hands | [ ]  | [ ]  | [ ]  |
| Dressing | [ ]  | [ ]  | [ ]  |
| Toileting | [ ]  | [ ]  | [ ]  |
| Transfer | [ ]  | [ ]  | [ ]  |
| Feeding | [ ]  | [ ]  | [ ]  |

**Part III：Application for Respite Service**

1. **Main Reason for Application:** (Please check the appropriate box(es).)

|  |  |
| --- | --- |
| [ ]  | Caregiver has to leave Hong Kong for a period of time |
| [ ]  | Temporary absence of domestic helper |
| [ ]  | Caregiver wants to take a short break |
| [ ]  | Caregiver has important personal matters to handle |
| [ ]  | Caregiver needs to be hospitalized for treatment or attending medical appointment |
| [ ]  | Others (please specify: |   | ) |

1. **Type of Respite Service:** (Please check in the appropriate box(es).)

**Residential Respite Service**

|  |  |
| --- | --- |
| [ ]  | Home for the Aged Places |
| [ ]  | Care and Attention Home Places (including Private RCHEs participated in the EBPS) |
| [ ]  | Contract Home Places |
| [ ]  | Nursing Home Places |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service Application Dates: | From |   | to |   |

|  |  |  |
| --- | --- | --- |
|  |   | days in total |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| The applicant has used residential respite service within the past 12 months prior to the application date: | [ ]  | No | [ ]  | Yes (please specify below) |

|  |  |  |  |
| --- | --- | --- | --- |
| From |   | to |   |
| From |   | to |   |
| From |   | to |   |

**Day Respite Service**

|  |  |
| --- | --- |
| [ ]  | Private RCHEs participated in the EBPS |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service Application Dates: | From |   | to |   |

|  |  |  |
| --- | --- | --- |
| Every: | Mon／Tue／Wed／Thu／Fri／Sat／Sun | \* |

|  |  |
| --- | --- |
|  | Or (for specific days) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Month: |   | Date: |   |

|  |  |  |
| --- | --- | --- |
|  |   | days in total |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| The applicant has used day respite service within the past 12 months prior to the application date: | [ ]  | No | [ ]  | Yes (please specify below) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Month: |   | Date: |   |
|  | Month: |   | Date: |   |
|  | Month: |   | Date: |   |

|  |
| --- |
| If yes, the applicant has undergone the medical check-up with Medical Examination Form: |
| [ ]  | No | [ ]  | Yes (if unable to provide a copy of Form, please provide the name of RCHE where the examination was  |
|  |  |  | conducted: |   | ) |

1. **Remarks (if any):**

|  |
| --- |
|  |

1. **Referring Agency:**

*(No need to fill out this section for applicant of day respite service without referring agency.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Agency: |   | Reference No.: |   |

|  |  |
| --- | --- |
| Address: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Worker |  | Countersigning Officer |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Signature: |  |
| Name: |  | Name: |  |
| Post: |  | Post: |  |
| Tel no.: |  | Tel no.: |  |
| Date: |  | Date: |  |

1. **Responsible Staff of RCHE:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of the Staff: |  | Telephone No.: |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Post: |   | Signature: |   | Date: |  |

1. **Caregiver:**

*(Applicable to the day respite service application without referring agency.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |   | Telephone No.: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |   | Date: |   |

(November 2023)

1. Residential Respite Service for the Elderly is applicable to Subvented Combined Home, Subvented Care and Attention Homes, Subvented Nursing Homes, Contract Homes and Private Residential Care Homes for the Elderly (RCHEs) participating in the Enhanced Bought Place Scheme (EBPS). [↑](#footnote-ref-1)
2. Day Respite Service for the Elderly in this application is applicable to Private RCHEs participating in the EBPS. [↑](#footnote-ref-2)