



Aged & Community Services
Association of NSW & ACT

AGED & COMMUNITY SERVICES ASSOCIATION OF NSW & ACT INC.

APPLICATION FOR INDUSTRY ADVICE SCHEME

NAME OF APPLICANT: _____

(Ie. the name under which the applicant organisation is registered with the Australian Tax Office as a Group Employer)

STREET ADDRESS: _____

_____ P/CODE: _____

POSTAL ADDRESS: _____

(If same as street address print "as above")

_____ P/CODE: _____

TELEPHONE NUMBER: () _____

FACSIMILE NUMBER: () _____

EMAIL ADDRESS: _____

ABN: _____

NATURE OF ORGANISATION: (Please tick where appropriate)

Incorporated under Companies Code

Partnership

Trust

Sole Trader

BOARD/ MANAGEMENT STRUCTURE:

Official Title: _____

(eg. Board of Management, Trustees if applicable.)

Name of *Chairperson/President/Managing Director/Owner:

(* Delete as appropriate)

CHIEF EXECUTIVE OFFICER:

Name: _____

Title: _____

Address: _____

Telephone Number: () _____

Facsimile Number: () _____

E-mail Address: _____

FACILITIES/SERVICES TO BE REGISTERED UNDER THIS AGREEMENT

RESIDENTIAL CARE FACILITIES:

Facility Details:

1 Name: _____
 Address: _____

 Contact Person: _____ Title: _____
 Telephone Number: () _____
 Facsimile Number: () _____
 E-mail Address: _____
 Type of Facility: _____ Number of Beds: _____
 (Nursing Home/Hostel)

2 Name: _____
 Address: _____

 Contact Person: _____ Title: _____
 Telephone Number: () _____
 Facsimile Number: () _____
 E-mail Address: _____
 Type of Facility: _____ Number of Beds: _____

3 Name: _____
 Address: _____

 Contact Person: _____ Title: _____
 Telephone Number: () _____
 Facsimile Number: () _____
 E-mail Address: _____
 Type of Facility: _____ Number of Beds: _____

4 Name: _____
 Address: _____

 Contact Person: _____ Title: _____
 Telephone Number: () _____
 Facsimile Number: () _____
 E-mail Address: _____
 Type of Facility: _____ Number of Beds: _____

(NB if space is insufficient, please add extra page/s)

SELF CARE/RETIREMENT VILLAGE FACILITIES:

Facility Details:

1) Name: _____
Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Type of Facility: _____ Number of Units: _____

2) Name: _____
Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Type of Facility: _____ Number of Units: _____

3) Name: _____
Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Type of Facility: _____ Number of Units: _____

4) Name: _____
Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Type of Facility: _____ Number of Units: _____

(NB if space is insufficient, please add extra page/s)

COMMUNITY AGED CARE PACKAGES:

CACP Details:

1 Name: _____
 Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Number of CACPs: _____

2 Name: _____
 Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Number of CACPs: _____

3 Name: _____
 Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Number of CACPs: _____

4 Name: _____
 Address: _____

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address: _____
Number of CACPs: _____

(NB if space is insufficient, please add extra page/s)

COMMUNITY CARE SERVICES:

Service Details:

- 1 Type of Service: (Pls circle) Day Care/Community Options/HACC/Other
Other:
Average Number of Clients:
Amount of Annual Recurrent Funding: _____
Name:
Address:

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address _____

- 2 Type of Service: (Pls circle) Day Care/Community Options/HACC/Other
Other:
Average Number of Clients:
Amount of Annual Recurrent Funding: _____
Name:
Address:

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address _____

- 3 Type of Service: (Pls circle) Day Care/Community Options/HACC/Other
Other:
Average Number of Clients:
Amount of Annual Recurrent Funding: _____
Name:
Address:

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address _____

- 4 Type of Service: (Pls circle) Day Care/Community Options/HACC/Other
Other:
Average Number of Clients:
Amount of Annual Recurrent Funding: _____
Name:
Address:

Contact Person: _____ Title: _____
Telephone Number: () _____
Facsimile Number: () _____
E-mail Address _____

(NB If space is insufficient, please add extra page/s)



CERTIFICATIONS: I/we certify that:

1. I/we have read and fully appreciate the ACS Statement of Philosophy received with this application.
2. I/we have received and read a copy of the details of the Industry Advice Scheme of the Aged & Community Services Association of NSW & ACT Inc and understand the rights, privileges and obligations of scheme members.
3. The information given herein is true and correct in every particular and I/we undertake to inform the Association promptly in the event of any change in particulars.

.....
(Name of applicant organisation)

I/we hereby apply for membership of the Aged & Community Services Association of NSW & ACT Inc Industry Advisory Scheme.

Signed:..... Title..... Date / /

Signed:..... Title..... Date / /

NOTES – FEES & SUBSCRIPTIONS:

An invoice for the rateable proportion of annual fees and subscriptions due in respect to your organisation’s agreement with the Association for the current year will be forwarded to you together with confirmation of acceptance of your application for Scheme membership.