



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: \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**FAX NUMBER:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**WEBSITE:** \_\_\_\_\_

**ABN:** \_\_\_\_\_

**NATURE OF ORGANISATION:** (Please tick where appropriate)

Incorporated under Companies Code   
Trust

Partnership   
Sole Trader

**BOARD/ MANAGEMENT STRUCTURE:**

**Official Title:** \_\_\_\_\_

(eg. Board of Management, Trustees if applicable)

**Name of \*Chairman/President/Managing Director/Owner: (\* Delete as appropriate)**

**CHIEF EXECUTIVE OFFICER:**

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Mobile:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_



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## **SERVICES TO BE REGISTERED UNDER THIS MEMBERSHIP**

### **RESIDENTIAL CARE FACILITIES:**

#### Facility Details:

- 1     Name: \_\_\_\_\_  
      Address: \_\_\_\_\_  
      \_\_\_\_\_  
      Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
      Phone Number: \_\_\_\_\_  
      Fax Number: \_\_\_\_\_  
      Email Address: \_\_\_\_\_  
      Type of Facility: \_\_\_\_\_ Number of Beds: \_\_\_\_\_  
      (High Care/Low Care/Self Care)
  
- 2     Name: \_\_\_\_\_  
      Address: \_\_\_\_\_  
      \_\_\_\_\_  
      Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
      Phone Number: \_\_\_\_\_  
      Fax Number: \_\_\_\_\_  
      Email Address: \_\_\_\_\_  
      Type of Facility: \_\_\_\_\_ Number of Beds: \_\_\_\_\_  
      (High Care/Low Care/Self Care)
  
- 3     Name: \_\_\_\_\_  
      Address: \_\_\_\_\_  
      \_\_\_\_\_  
      Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
      Phone Number: \_\_\_\_\_  
      Fax Number: \_\_\_\_\_  
      Email Address: \_\_\_\_\_  
      Type of Facility: \_\_\_\_\_ Number of Beds: \_\_\_\_\_  
      (High Care/Low Care/Self Care)
  
- 4     Name: \_\_\_\_\_  
      Address: \_\_\_\_\_  
      \_\_\_\_\_  
      Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
      Phone Number: \_\_\_\_\_  
      Fax Number: \_\_\_\_\_  
      Email Address: \_\_\_\_\_  
      Type of Facility: \_\_\_\_\_ Number of Beds: \_\_\_\_\_  
      (High Care/Low Care/Self Care)

(N.B. If space is insufficient, please add extra page/s)



**COMMUNITY AGED CARE PACKAGES/EACH PACKAGES:**

**CACP/EACH/EACHD Details:**

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Number of CACP/EACH/EACHD: \_\_\_\_\_  
(Please circle)
  
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Number of CACP/EACH/EACHD: \_\_\_\_\_  
(Please circle)
  
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Number of CACP/EACH/EACHD: \_\_\_\_\_  
(Please circle)
  
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Number of CACP/EACH/EACHD: \_\_\_\_\_  
(Please circle)

(N.B. If space is insufficient, please add extra page/s)



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## **COMMUNITY CARE SERVICES:**

### Service Details:

1. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other  
Other:  
Average Number of Clients:  
Name:  
Address:  
  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_
  
2. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other  
Other:  
Average Number of Clients:  
Name:  
Address:  
  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_
  
3. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other  
Other:  
Average Number of Clients:  
Name:  
Address:  
  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_
  
4. Type of Service: (Pls circle) Day Care/Day Therapy/HACC/Other  
Other:  
Average Number of Clients:  
Name:  
Address:  
  
Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

(N.B. 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 Advice 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. Please ensure you have completed the Revenue Survey Form that accompanies this membership application form.