Elderly Services

3, Ċentru Servizz Anzjan, Old Mint Street, Valletta, VLT 1510
Email: aacc-services@gov.mt
Website: aacc.gov.mt
Freephone: 153
Telephone: 22788900

I am filling in the form: * ☐ For myself ☐ On behalf of someone else

* *Indicates mandatory information*

Section 1: Applicant's Details

Name: * _____ Surname: * _____

Identity Card Number: * _____ Date of Birth: * (DD/MM/YYYY) _ _ / _ _ / _ _ _ _

Gender: * ☐ Male ☐ Female ☐ Other

Nationality: * ☐ Maltese ☐ EU ☐ Other (Name Country of Origin) _____

Civil Status *

☐ Single ☐ Married ☐ Cohabitation

☐ Civil Union ☐ Widow/er ☐ Separated

☐ Divorced

Additional Information

Entitlement Number: _____ (please attach a copy)

Special Identity Card: _____ (please attach a copy)

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

Yellow Card *(for those suffering from diabetes)* ☐ Yes ☐ No

Contact Details *

Address:

House Name / Number: _____ Locality: _____

Street: _____ Post Code: _____

Contact Number: _____ Email: _____

Section 2: Details of Relatives (kindly list details of spouse if applicable, and children. In case of no children list siblings) *

	1st Relative	2nd Relative	3rd Relative
Name and Surname of your Next of Kin: *			
Identity Card Number:			
Relation to Applicant: *			
Contact Number: *			
Email:			
Power of Attorney or Person of Trust:			
Lives in the same Residence? *	Yes / No	Yes / No	Yes / No

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.

Referenza		Servizz	Referenza		Servizz
☐	1	Active Ageing Centres (Medical Report Required)	☐	10c	Domiciliary Dietitian Service (Medical Report Required)
☐	2	Home Help Service (Medical Report Required)	☐	11	Carer at Home Scheme (Medical Report Required)
☐	3	Respite at Home (Medical Report Required)	☐	12a	Dementia Intervention Team (Medical Report Required)
☐	4	Residential Respite (Medical Report Required)	☐	12b	Day/Night Dementia Activity Centre (Medical Report Required)
☐	5	Handyman Service	☐	13	Social Work
☐	6a	Telecare+ (Telecare+ Application Required)	☐	14	Night Shelter (Medical Report Required)
☐	6b	Telecare on the Move (Medial Report Required)	☐	15	Home Admission (Medical Report Required)
☐	7	Telephone Rent Rebate (Pink Form Required)	☐	16	Community Geriatrician (Medical Report & Ticket of Referral Required)
☐	8	Meals on Wheels (Medical Report Required)	☐	17	Podology (Medical Report Required)
☐	9	Continence Service (Medical Report Required)	☐	18	Physiotherapy (Medical Report Required)
☐	10a	Domiciliary Nursing (Medical Report & Referral of GP Required)	☐	19	Occupational Therapy (Medical Report Required)
☐	10b	Domiciliary Caring (Medical Report Required)	☐	20	Psychotherapy Service (Medical Report Required)

For Active Ageing Centres (Reference 1), please indicate Locality: _____

For Home Help Service provision (Reference 2), please indicate who lives in the residence in Section 2 and also submit a Medical Report for every person over 65 years residing in the same residence.

For Telecare+ Service (Reference 6a), kindly fill in and submit as well the following:

- **Filled Telecare+ application form** (click here to download document)
- Copy of **a valid Pink Form** issued by the Department of Social Security **or** a copy of **a valid Yellow Card** issued by the Department of Health proving that applicant is diabetic (if applicable)
- **Medical report** signed by a General Practitioner (**if person is under sixty years of age**)

For Telecare on the Move Service (Reference 6b), kindly fill in this application form and also submit the following documents:

- Copy of **a valid Pink Form** issued by the Department of Social Security, if available

Section 4: Medical Report (To be filled by a Doctor as applicable) *

1. **Medical History and Diagnosis**

2. **Communication Abilities**

3. **Psychological 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. **List of Medications**

7. **Social Situation**

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

8. **Domiciliary Allied Health Intervention**

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

9. **For Continence Service** kindly indicate a valid clinical reason. If pull ups are being requested specify reason why pull ups and not another product _____

10. **Other Relevant Information** (include other clinics / services used)

_____ Name and Surname (Doctor)

_____ Medical Council Number

_____ Signature (Doctor)

_____ Contact Number (Doctor)

_____ Date

Rubber Stamp

Declaration

Active Ageing and Community Care collects and processes all relevant personal data to provide its services to individuals who qualify for them. This is done to carry out its functions under Maltese and European legislation.

Personal data is processed in accordance with the General Data Protection Regulation (EU) 2016/679 (GDPR) and the Data Protection Act (Cap. 586.). Such data may be disclosed to other departments and/or authorities in an electronic or manual form which are directly related to the functions pertaining to Active Ageing and Community Care, and in order to verify the information submitted by you and ensure its accuracy in relation to the claim, however it will not be disclosed to other third parties unless obliged by law.

You may request in writing to be informed of all the personal information held about you, and to rectify or erase incorrect information. Such a request is to be addressed to "The Data Controller", Active Ageing and Community Care, FXB Building, Mdina Road, Qormi QRM 9014 or by email to dp.aacc@gov.mt and appropriate action would be taken at the earliest possible time. In making such a request, kindly quote your identity card number, your name and address and other relevant documentation to identify your case.

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 and retained afterwards. Data will not be retained longer than necessary.

Name and Surname of Applicant in Block Letters _____

Signature of Applicant _____

Identity Card Number _____

Date _____

Complete Applications are to be sent to:

Active Ageing and Community Care
3, Ċentru Servizz Anzjan, Old Mint Street,
Valletta, VLT 1510

Email: aacc-services@gov.mt

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

Name and Surname in Block Letters of employee receiving application _____

Signature of person receiving application _____

Other remarks _____

Date _____