

# Elderly Services



3, Ċentru Servizz Anzjan, Old Mint Street, Valletta, VLT 1510  
Email: aacc-services@gov.mt  
Website: www.activeageing.gov.mt  
Freephone 153  
Telephone: 22788800

*\* 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: \_\_\_\_\_  
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: \_\_\_\_\_ e-mail: \_\_\_\_\_

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

|                                       | 1 <sup>st</sup> Relative | 2 <sup>nd</sup> Relative | 3 <sup>rd</sup> Relative |
|---------------------------------------|--------------------------|--------------------------|--------------------------|
| Name & Surname of your Next of Kin:   |                          |                          |                          |
| Identity Card Number:                 |                          |                          |                          |
| Relation to Applicant:                |                          |                          |                          |
| Contact Number:                       |                          |                          |                          |
| E-mail:                               |                          |                          |                          |
| 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.

| Reference                    | Service  | Reference                    | Service   |
|------------------------------|--|------------------------------|---|
| <input type="checkbox"/> 1   | Active Ageing Centres <small>(Medical Report Required)</small> | <input type="checkbox"/> 10c | Domiciliary Dietitian Service <small>(Medical Report Required)</small>      |
| <input type="checkbox"/> 2   | Home Help Service <small>(Medical Report Required)</small>     | <input type="checkbox"/> 11  | Carer at Home Scheme <small>(Medical Report Required)</small>               |
| <input type="checkbox"/> 3   | Respite at Home <small>(Medical Report Required)</small>       | <input type="checkbox"/> 12a | Dementia Intervention Team <small>(Medical Report Required)</small>         |
| <input type="checkbox"/> 4   | Residential Respite <small>(Medical Report Required)</small>   | <input type="checkbox"/> 12b | Day/Night Dementia Activity Centre <small>(Medical Report Required)</small> |
| <input type="checkbox"/> 5   | Handyman Service   | <input type="checkbox"/> 13  | Social Work   |
| <input type="checkbox"/> 6a  | Telecare+ <small>(Telecare+ Application Required)</small>      | <input type="checkbox"/> 14  | Night Shelter <small>(Medical Report Required)</small>                      |
| <input type="checkbox"/> 6b  | Telecare on the Move <small>(Medical Report Required)</small>  | <input type="checkbox"/> 15  | Home Admission <small>(Medical Report Required)</small>                     |
| <input type="checkbox"/> 7   | Telephone Rent Rebate <small>(Pink Form Required)</small>      | <input type="checkbox"/> 16  | Community Geriatrician  |
| <input type="checkbox"/> 8   | Meals on Wheels <small>(Medical Report Required)</small>       | <input type="checkbox"/> 17  | Podology <small>(Medical Report Required)</small>                           |
| <input type="checkbox"/> 9   | Continence Service <small>(Medical Report Required)</small>    | <input type="checkbox"/> 18  | Physiotherapy <small>(Medical Report Required)</small>                      |
| <input type="checkbox"/> 10a | Domiciliary Nursing <small>(Medical Report Required)</small>   | <input type="checkbox"/> 19  | Occupational Therapy <small>(Medical Report Required)</small>               |
| <input type="checkbox"/> 10b | Domiciliary Caring <small>(Medical Report Required)</small>    | <input type="checkbox"/> 20  | Psychotherapy Service <small>(Medical Report Required)</small>              |

**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)
- Copy of **Identity Card**
- **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:**

- **Medical report** signed by a General Practitioner
- 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 & Diagnosis**

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**2. Communication Abilities**

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**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   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grooming  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bathing   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Toileting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mobility  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**6. List of Medications**

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**7. Social Situation**

The applicant:     Lives Alone       Lives with Someone Else       Support 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)

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\_\_\_\_\_  
Name & Surname (Doctor)

\_\_\_\_\_  
Medical Council Number

\_\_\_\_\_  
Signature (Doctor)

\_\_\_\_\_  
Contact No. (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 [dpaacc.msca@gov.mt](mailto:dpaacc.msca@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 & Surname of Applicant in Block Letters \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Identity Card \_\_\_\_\_

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](mailto:aacc-services@gov.mt)**

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

Name & Surname in Block Letters of employee receiving application \_\_\_\_\_

Signature of person receiving application \_\_\_\_\_

Other remarks \_\_\_\_\_

Date \_\_\_\_\_