Tuiste vir Bejaardes

001-194 NPO

POSBUS 10405
ASTON MANOR
1630

CACTUSLAAN
ALLEN GROVE
KEMPTONPARK
1619

Epos: colleen@herfsland.co.za
lennie@herfsland.co.za
Tel: 011 972 5417/8
Faks: 011 391 2104

INFORMATION FOR NEW APPLICANTS

Please complete the following forms:

1. Application form
2. Medical certificate
3. Declarations of income an assets
4. List of addresses of children/family
5. Deposit, registration and collection fees

Please return the abovementioned forms with the following documentation as soon as possible to the nursing service manager:

1. Copy of ID
2. Copy of medical aid card
3. Financial information – Proof of income, proof of pension or copy of 3 months bank statement (not older than 3 months)

You will receive the following information on admission:

1. Household rules
2. Residential contract
3. List of necessities

It is a requirement of the Department of Social Development to supply **proof of income** with every application and admission. This include proof for pension, interest on investment and any other income, not older than three months.

Your applicaton will only be considered once all the above mentioned forms have been fully completed and handed in.

Mrs Johannie Louw
Manager

PART OF
DEEL VAN
Tutela
OMGEE BRING HOOP CARING BRINGS HOPE

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APPLICATION FORM

ANSWER ALL THE QUESTIONS. MARK WITH A CROSS, WHERE APPLICABLE.

1	Surname						
2	Full names						
	First name						
3	Gender	Male		Female			
4	Date of birth	19 YY	MM	DD	I.D. nr		
5	Current address						
	Contact numbers						
7	With whom are you staying now?						
8	Names, addresses and contact numbers of two other relatives						
					Tel.		
					Tel.		
					Tel.		
					Tel.		
9	Marriage status	Married		Widow		Divorce	
		Never being married		Widower		Seperated	
10	Since when are you divorced / widow / widower / seperated?						
11	Home language		Church denomination				
12	Current Congregation						
13	Who is your current referent / pastor?						

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DEEL VAN
Tutela
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14	**Regarding your health:**	YES	NO
	Can you walk comfortable outside on your own?		
	Can you walk indoors without difficulty?		
	Can you bath without help?		
	Can you dress without help?		
	Can you have your meals without help?		
	Can you wash yourself without help?		
	Are you confined to bed most of the time?		
	Do you have control over bladder and bowel functions?		
15	**How is your general state of health:**		
	Good		
	Changeable/Uncertain		
	Weak/poor		
16	Do you have a specific ailment or health issue e.g diabetes, epilepsy, blndness, deafness etc. Please give details	Yes	No
17	Are you allergic to any medical preparations? Please give details	Yes	No
18	Any foods you have to avoid? If yes, specify	Yes	No
19	Who is your house doctor?		
20	Medical Aid and plan	Medical Aid nr	
21	From which Pharmacy do you receive your medicine?		
22	When do you wish to be admitted in the home?		

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23	Funeral Society		Policy number	
24	Who has charge of your funeral policy?			

	Which do you prefer:	Burial		Cremation	

The following documents MUST accompanied by your application form:

1. Copy of ID
2. Medical certificate
3. Copy of medical aid card
4. Declaration of income and assets
5. Financial information – Proof of income, proof of pension or copy of 3 months bank statement (not older than 3 months)
6. Deposit, registration and collection fees
7. List of Addresses of children/family

BASIS OF ADMISSION:

I confirm the following:

- If admitted to Herfsland, I will comply with all the rules and regulations of the Home.
- Information supplied in this application form and my statement regarding my income and assets, is true and just and provides the basis for my admission and residence in the home as well as the establishment of fees payable by me.
- Management may request any medical examination, as prescribed by management, to be carried out.

____
SIGNATURE OF APPLICANT /
RESPONSIBLE PERSON

Signed at ________________________

Date _____________

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MEDIESE SERTIFIKAAT: Aansoek vir opname in 'n Tuiste vir Bejaardes
MEDICAL CERTIFICATE: Application for admission to a Home for the Aged

Moet deur mediese praktisyn voltooi word / To be completed by medical practitioner														
Volle naam van applikant Full name of applicant														
Geboorte datum Date of birth														
Identiteitsnommer Identification number														
Ras / Race					Geslag/Gender									

1. ALGEMEEN / GENERAL:

Lengte/ Height		Gewig/Weight	

2. SPYSVERTERINGSTELSEL / ALIMENTARY SYSTEM:

Klagtes: Slegte spysvertering / Mantelvliesbreuk / Hardlywigheid / Sooibrand	
Complaints: Indigestion / Hiatus Hernia / Constipation / Heart-burn	

3. GESIGVERMOË / VISION

Klagtes: Oogpêrel / gloukoom / gesigsverlies	
Complaints: Cataracts /glaucoma / loss of vision	

4. GEHOOR / HEARING

Klagtes: Verlies	
Complaints: Loss	

5. BLOEDSOMLOOPSTELSEL / CIRCULATORY SYSTEM

A	Bloeddruk / Blood pressure	
B	Pols / Pulse	
C	Perifere sirkulasie / Peripheral circulation	
D	Sianose / Cyanosis	
E	Klagtes / Complaints	

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6. ASEMHALINGSSTELSEL / RESPIRATORY SYSTEM

A	Spoed / Speed	
B	Lugweë / Air entry	
C	Geskiedenis van ondergrond werk History of working underground	
D	Klagtes / Complaints	

7. SKELET-SPIER / MUSCULAR-SKELETAL SYSTEM

A	Beweeglikheid / Gait	
B	Artritis / Arthritis	
C	Spastisiteit / Spasticity	
D	Gebreklikheid / Deformities	
E	Bedgebonde / rystoel / stap stoel / ambulant Bedridden / wheelchair / walking aid / ambulant	

8. GESLAG-URINE STELSEL / GENITO-URINARY SYSTEM

A	Inkontinensie en klagtes Incontinence and complaints	

SLEGS VROULIKE APPLIKANTE / FEMALE APPLICANTS ONLY

Vorige Ginekologiese / Obstetriese geskiedenis Previous Gynaecological / Obstetrical history	

9. HEPATITIS B:

Heg aparte laboratoriumverslag aan (Vir rekening van pasiënt)
Include separate Laboratory report (At expense of patient)

10. SENUWEESTELSEL / NERVOUS SYSTEM

A	Tremor / Tremors:	
B	Duiseligheid / Vertigo:	
C	Hoofpyn / Headaches:	
D	Epilepsie / Epilepsy:	
E	Perifere Neuropatie / Peripheral Neuropathy:	
F	Klagtes / Complaints:	

11. KLIERE / GLANDS

A	Borste / Breasts:	
B	Skildklier / Thyroid Gland:	
C	Pankreas-diabetes / Pancreas-diabetes:	
D	Prostaat / Prostate gland:	
E	Klagtes / Complaints:	

12. GEESTESTOESTAND / MENTAL STATE

Oriëntasie / geheue / emosionele toestand Orientation / memory / emotional state:	

13. SLAAPPATROON / SLEEPING PATTERN

Gaan vroeg slaap / raak moeilik aan die slaap / word vroeg wakker: Goes to bed early / has difficulty in falling asleep / awakens early:	

14. GEWOONTES / HABITS

A	Rook / Smoke:	
B	Alkohol / Alcohol:	
C	Lakseermiddels / dwelmmiddels / medikasie Laxatives / drugs / patent medication:	

15. VEL / SKIN

Letsels / Uitslag / Littekens Lesions / Rashes / Scars:	

16. VOETE / FEET

Eelte / Liddorings / Edeem / Naels Callosity / Corns / Oedema / Toenails	

17. DIEET / DIET

Sagte Diëet / Soft Diet Normale Diëet / Normal Diet	

18. **ANDER / OTHER**

A	Allergieë Allergies:	
B	Hulpmiddels: Bril, Gehoortoestel, Prostese Aids: Glasses, Hearing aid, Prosthetic Aid	
C	Operasies Operations:	

19. **HUIDIGE DIAGNOSE / PRESENT DIAGNOSIS**

20. **HUIDIGE MEDIKASIE – Voorsien asseblief 'n oorspronklike voorskrif vir uitreiking van medikasie**
PRESENT MEDICATION- Please provide an original script in addition as required for dispensing purposes.

MEDIESE PRAKTISYN (Naam voluit) MEDICAL PRACTIONER (Full name)	
ADRES / ADDRESS	
HANDTEKENING / SIGNATURE	
DATUM / DATE	

PART OF DEEL VAN Tutela OMGEE BRING HOOP CARING BRINGS HOPE

DECLARATION OF INCOME AND ASSETS

NAME OF RESIDENT			
A. INCOME		MONTHLY INCOME	
TYPE OF PENSION	REFERENCE NUMBER:	SELF	SPOUSE
1.			
2.			
3.			

INVESTMENTS:				
FINANCIAL INSTITUTION	AMOUNT INVESTED	INTEREST		
1.				
2.				
3.				

ANY OTHER INCOME			
1.			
2.			
NO INCOME (MARK WITH X)			
	TOTAL		

B. ASSETS SOLD/DONATIONS MADE IN THE LAST 5 YEARS		
	DATE	AMOUNT
1. Assets sold		
2. Assets donated		
3. Cash donated		

1. I declare that the above information as provided by me is true and correct according to the best of my knowledge.
2. I, the undersigned, hereby declared that in case of any income or assets no declare by me, I will be held responsible by the Board of Control to pay any outstanding fees not paid by me for this reason. A certificate signed by the chairman of the Boad of Control will suffice as proof of the amount payable by me.
3. I irrevocably and in *rem suam* authorize the Board of control to use its own discretion to investigate the information regarding my income and assests.

____ ________________

SIGNATURE OF RESIDENT/RESPONSIBLE PERSON DATE

PART OF DEEL VAN Tutela

OMGEE BRING HOOP CARING BRINGS HOPE

LIST OF ADDRESSES OF CHILDREN / NEXT OF KIN

NAME OF RESIDENT:	

NB Please put the name and address of the person who is responsible for the communication and payment for the resident, first on the list.

RELATIONSHIP	NAME AND SURNAME	POSTAL ADDRESS	STREET ADDRESS	CONTACT NUMBERS
				H W Cel Email
				H W CEL Email
				H W CEL Email
				H W CEL Email

PART OF DEEL VAN Tutela OMGEE BRING HOOP CARING BRINGS HOPE

DEPOSIT, REGISTRATION AND COLLECTION FEES

1. A Registration fee of R350.00 per person is payable with admittance.

2. A R3 000 refundable deposit is payable with admittance. With death or discharge any outstanding monies will be deducted from this deposit.

3. The cost of temporarily accommodation will be calculated per day.

4. Accommodation is payable in advance before or on the 7th of each month.

5. Interest(prima plus 2%) will be imposed on overdue accommodation account.

6. A fee of R75 will be imposed for collection of accommodation fees if not paid before or on the 7th of the month.

Signed on this _______day of _______________________20 _______at_______________________n

____

SIGNATURE OF APPLICANT /
RESPONSIBLE PERSON

PART OF
DEEL VAN
Tutela
OMGEE BRING HOOP CARING BRINGS HOPE