



Tuiste vir Bejaardes

001-194 NPO

POSBUS 10405  
ASTON MANOR  
1630

CACTUSLAAN 21  
ALLEN GROVE  
KEMPTONPARK  
1619

Epos: manager@herfsland.co.za  
lennie@herfsland.co.za  
Tel: 011 972 5417/8

## INFORMATION FOR NEW APPLICANT

Please complete the following forms:

1. Application form
2. Medical certificate
3. Declarations of income and 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)
4. Latest script

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 includes proof for pension, interest on investment and any other income, not older than three months.

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

**Mrs Ilze Pieterse**  
Manager



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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	<input type="checkbox"/>	Female	<input type="checkbox"/>		
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	<input type="checkbox"/>	Widow	<input type="checkbox"/>	Divorce	<input type="checkbox"/>
		Never being married	<input type="checkbox"/>	Widower	<input type="checkbox"/>	Seperated	<input type="checkbox"/>
10	Since when are you divorced / widow / widower / seperated?						
11	Home language				Church denomination		
12	Current Congregation						
13	Who is your current referent / pastor?						

14	<b>Regarding your health:</b>	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	<b>How is your general state of health:</b>		
	Good		
	Changeable/Uncertain		
	Weak/poor		
16	Do you have a specific ailment or health issue e.g diabetes, epilepsy, blindness, 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?		

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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## MEDICAL CARE

Hereby, I as the medical doctor of \_\_\_\_\_  
take note that he/she will be admitted to Herfsland Home for the Aged, 21 Cactus Road, Allen  
Grove, Kempton Park.

I am willing to see him/her at Herfsland, if necessary. Yes / No

or

I refer \_\_\_\_\_ to the medical doctor available at Herfsland or  
the doctor recommended by his/her family.

Signature \_\_\_\_\_ Date \_\_\_\_\_

STAMP

## MEDIESE BEHANDELING

Hiermee neem ek, as die mediese dokter van \_\_\_\_\_,  
kennis dat hy/sy by Herfsland Tuiste vir Bejaardes, Cactus straat 21, Allen Grove, Kempton  
Park opgeneem gaan word.

Ek sou bereid wees om hom/haar by Herfsland te kom sien indien nodig Ja / Nee

of

Ek verwys \_\_\_\_\_ na die mediese dokter beskikbaar by  
Herfsland of wat deur hul familie voorgestel word.

Signature \_\_\_\_\_ Datum \_\_\_\_\_

STAMP

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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	
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**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	

**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	Gebrekkigheid / 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	
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**SLEGS VROULIKE APPLIKANTE / FEMALE APPLICANTS ONLY**

Vorige Ginekologiese / Obstetriesse geskiedenis Previous Gynaecological / Obstetrical history	
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**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. LIERE / 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:	
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**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:	
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**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:	
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**16. VOETE / FEET**

Eelte / Liddorings / Edeem / Naels Callosity / Corns / Oedema / Toenails	
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**17. DIEET / DIET**

Sagte Diëet / Soft Diet Normale Diëet / Normal Diet	
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**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.


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

## DECLARATION OF INCOME AND ASSETS

<b>NAME OF RESIDENT</b>			
<b>A. INCOME</b>		<b>MONTHLY INCOME</b>	
<b>TYPE OF PENSION</b>	<b>REFERENCE NUMBER:</b>	<b>SELF</b>	<b>SPOUSE</b>
1.			
2.			
3.			
<b>INVESTMENTS:</b>			
<b>FINANCIAL INSTITUTION</b>	<b>AMOUNT INVESTED</b>	<b>INTEREST</b>	
1.			
2.			
3.			
<b>ANY OTHER INCOME</b>			
1.			
2.			
<b>NO INCOME (MARK WITH X)</b>			
<b>TOTAL</b>			
<b>B. ASSETS SOLD/DONATIONS MADE IN THE LAST 5 YEARS</b>			
	<b>DATE</b>	<b>AMOUNT</b>	
<b>1. Assets sold</b>			
<b>2. Assets donated</b>			
<b>3. Cash donated</b>			

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

**LIST OF ADDRESSES OF CHILDREN / NEXT OF KIN**

<b>NAME OF RESIDENT: :</b>	
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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

## 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 \_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OF APPLICANT /  
RESPONSIBLE PERSON