APPLICATION FOR ADMISSION TO FACILITY FOR THE AGED

BADISA
Christelike Barmhartigheid
Christian Compassion

☐ **Frail Care**

HOME FOR THE AGED ..... ☐ **Residence**

1. **SURNAME:** _____

2. **NAMES IN FULL:** _____

3. **ID. NO:** ☐☐☐☐☐☐ ☐☐☐☐ ☐☐ ☐

4. **DATE OF BIRTH:** ☐☐☐☐ ☐☐ ☐☐

5. **ADDRESS:** _____

   _____

6. **TELEPHONE NO:** _____ (Code: _____) [Self]

   TELEPHONE NO: _____ (Code: _____) [Contact person]

7. **SEX:** Male ☐ Female ☐

8. **MARRIED/WIDOWED/DIVORCED/SINGLE** _____

9. **NAME OF SPOUSE (IF MARRIED):** _____

   OR WHEN DECEASED, DIVORCED OR ESTRANGED: _____

10 **HOME LANGUAGE** _____ 11. **RELIGIOUS DENOMINATION:** _____

12. **FORMER OCCUPATION:** _____

13. **PERSON/ORGANISATION RESPONSIBLE FOR FUNERAL COSTS:**

    Name: _____

    Address: _____

    _____

    Telno: _____ (Code _____)

14. **DO YOU HAVE A WILL?** ☐ Yes ☐ No

WHO IS THE EXECUTOR? _____

Address: _____

_____

Telno: _____ (Code _____)

15. **NAME OF HOSPITAL AND FILE NO:** _____

16. **NAME OF MEDICAL AID:** _____

Medical Aid Number: _____

17. **HOW MANY CHILDREN DO YOU HAVE?** _____

18. **PARTICULARS OF ALL CHILDREN (OR NEXT OF KIN IF YOU HAVE NO CHILDREN)**

Names	Addresses and Telno's	Kinship	Occupation
[1]			
[2]			
[3]			
[4]			
[5]			

Names	Addresses and Telno's	Kinship	Occupation
[6]			
[7]			

[Should space be insufficient, please add separate list]

19. **WHERE ARE YOU AT PRESENT?**

☐ Own house ☐ Flat ☐ Children ☐ Hospital ☐ Care Centre

20. **STATE OF HEALTH?** _____

_____

Do you need help with regard to the following?

☐ mobility (specify) _____

☐ bath/wash/eat/dress _____

☐ medical diagnosis (eg heart diseases, high blood pressure, other)

_____

_____

_____

21. **WHEN DO YOU WANT TO BE ADMITTED:** ☐ As soon as possible ☐ Later

22. **I HEREBY STATE** that all details given in this application form are, to my knowledge, true and correct. Should I be admitted to the Home, I undertake to abide by the rules and regulations of the Home, even if it are changed from time to time.

SIGNATURE OF APPLICANT
(0R AN AUTHORISED PERSON)

DATE

SKDB/BS 02

MEDICAL CERTIFICATE: APPLICATION FOR ADMISSION TO AN OLD AGE HOME/FRAIL CARE SECTION

1. **FULL NAME AND SURNAME:** _____

2. **AGE:** _____

3. **APPLICANT'S COMPLAINTS (History, symptons and previous treatment):**

_____

_____

_____

_____

_____

4. **GENERAL EXAMINATIONS:**

4.1 **General physical and nutritional state**

_____

_____

4.2 **Respiratory system**

_____

_____

4.3 **Cardio vascular system** **Blood pressure:** _____ / _____
(Must be taken in all cases)

_____

_____

4.4 **Genito-Urinary system (Urine to be tested in all cases)**

_____

_____

4.5 **Elementary and other abdominal systems**

_____

_____

4.6 **Muscular-Skeletal system** **(State abnormalities)**

_____

_____

4.7 **Central nervous system**

4.8 **Mental Condition (Suffers he/she from the following conditions?)**

Depression:

Senile dementia:

Psychotic/Neurotic:

Aggresive behaviour:

Give a description of the above conditions if it is applicable and if institutional care is important

4.9 **Other conditions (Does the patient suffer from any of the following?)**

Rheumatism ☐ Chronic osteo-arthritis ☐ Tabes dorsalis ☐ Myopathy ☐

Earlier hemiplegia ☐ Cerebral atrophy ☐ Parkinsons ☐

Skin problems ☐ Contagious illnesses ☐ Allergy ☐

4.10 **Is the applicant incontinent?**

4.11 **Has the applicant difficulties with:** Hearing ☐ Vision ☐ Speech ☐

4.12 **Was any malignancy (cancerous) diagnosed? (Describe)**

4.13 **Has the applicant any history of alcohol or drug dependance? (Describe)**

4.14 **Is the applicant:** [a] Permanently bedridden? ☐ [b] Confined to a wheelchair? ☐

4.15 **Does the applicant require regular assistance with respect of mobility, dressing, feeding and personal hygiene?** **(Describe in detail if it is applicable)**

Mobility: _____

_____

Dressing: _____

_____

Feeding: _____

_____

Medication: _____

_____

Personal Hygiene: _____

_____

5. **PRESENT MEDICATION (Full details)**

_____

_____

_____

_____

_____

6. **HOW LONG HAVE YOU BEEN TREATING THE APPLICANT?** _____

7. **GENERAL REMARKS:**

_____

_____

_____

_____

_____

_____ _____ _____

MEDICAL PRACTITIONER [PRINT] **MEDICAL PRACTITIONER [PRINT]** **DATE**

Address: _____

Telno: _____ (Code _____)

SKDB/BS 03

REPORT OF SOCIAL WORKER

1. **SURNAME:** _____

FULL NAMES: _____

DATE OF BIRTH: ☐☐☐☐ ☐☐ ☐☐

ADDRESS: _____

_____

TELEPHONE NO: _____ (Code: _____)

2. **FAMILY AND RELATIONSHIPS:**

_____

_____

_____

_____

_____

_____

3. **PERSONAL PARTICULARS** (Personality, interests, adjustment to group situation, etc):

_____

_____

_____

_____

_____

_____

4. **ENVIRONMENT AND HOUSING SITUATION** (Living circumstances, motivation for admission, housing problems):

_____

_____

_____

_____

_____

_____

5. **PHYSICAL CONDITION (General physical state, assistance with regard to care, allergies, treatment, hospitalisation, etc):**

6. **MENTAL CONDITION (Recall of recent events, understanding, depression, psychoses, aggressive behaviour):**

Psychiatric report included? Yes ☐ No ☐

7. **ECONOMICAL SITUATION:**

8. **REASONS FOR ADMISSION (Age, social circumstances, housing problems, physical deterioration, financial circumstances, loneliness):**

9. **SERVICES ALREADY RECEIVED (Also other applications for admission)**

10. **RECOMMENDATION (Specify type of placement, eg room, sick bay, flat)**

11. **MOTIVATION WITH REGARD TO NON-AGED/DISABLED:**

SOCIAL WORKER	NAME OF ORGANISATION	DATE

SKDB BS 03(a)

BRIEF SOCIAL REPORT

Dear Rev/Pastor/Mr/Mrs/Miss

This report must be completed by a minister/pastor/social worker as soon as possible. Should the required social particulars not be provided, the application for admission to an old age home can not be accepted.

*Please send the completed report **confidentially** and as soon as possible to the address below.*

Yours faithfully

MANAGER/MATRON ***DATE***

ADDRESS: _____

_____

_____

SOCIAL REPORT ON: Mr/Mrs/Miss _____

Address: _____

_____

_____

How long do you know the applicant: _____

A. PHYSICAL AND MENTAL CONDITION

Can the applicant:

	Yes	**No**	**To a certain extent**
* Cook and prepare food	☐	☐	☐
* Clean the house and keep it tidy	☐	☐	☐
* Bath alone	☐	☐	☐
* Dress alone	☐	☐	☐
* Eat alone	☐	☐	☐
* Move around freely without assistance	☐	☐	☐

Health: ☐ Good ☐ Changeable ☐ Poor ☐ Mentally alert

☐ Forgetful ☐ Signs of disinterest

☐ Clear signs of senility

B. **PRESENT ACCOMMODATION:** ☐ Own home ☐ Rental Home ☐ Hotel
☐ Old age home ☐ Hospital ☐ Reside with others ☐ Reside with own children

Permanence of accommodation: ☐ Permanent ☐ Uncertain ☐ Must vacate
☐ Can stay, but circumstances are experienced as unsuitable by the elderly person

Give reasons: _____

_____

_____

_____

C. **SOCIAL CIRCUMSTANCES:**

Care: ☐ Care for self ☐ Cared for by children/family/friends/others

Quality of Care: ☐ Good ☐ Reasonably good ☐ Unsuitable

Social contacts: ☐ Sufficient contact with family/friends
☐ Limited contact ☐ Entirely alone

Social adaptability: ☐ Well adapted ☐ Difficult social situation
☐ Depression ☐ Behaviour problems

Give details: _____

_____

_____

_____

D. **REASONS FOR ADMISSION:** _____

_____

_____

E. **RECOMMENDATION:** _____

_____

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MINISTER/PASTOR/SOCIAL WORKER **DATE**

ADDRESS: _____

_____

_____

SKDB/BS 04

STATEMENT OF INCOME AND EXPENDITURE
(Documentary proof of income/expenditure must be attached)

NAME OF APPLICANT: _____

A. INCOME 1. PENSION RECEIVED (Type of pension) Paypoint [e.g. bank/post office]	Ref no	Monthly Income	
		Self	Spouse
1.1			
1.2			
1.3			
2. ANNUITY (Name of fund)			
2.1			
2.2			
2.3			
3. INCOME FROM TRUST FUNDS AND MAINTENANCE ALLOWANCES (Name of fund/person)			
3.1			
3.2			
3.3			
4. SHARES (Name of fund)			
4.1			
4.2			
4.3			
5. DIRECTORS FEES (Name of company)			
5.1			
5.2			
5.3			
6. CASH INVESTMENTS (Specify financial institution)	Amount invested	Monthly interests	
		Self	Spouse
6.1			
6.2			
6.3			
6.4			
6.5			

7. FIXED PROPERTY (e.g. farms dwellings) Full description and where situated	Municipal assesment	Bond in arrears	Monthly Income	
			Self	Spouse
7.1				
7.2				
8. OTHER SOURCES OF INCOME (e.g. Income from business usufruct/Fidei Commissum) Please specify			**Self**	**Spouse**
8.1				
8.2				
8.3				
8.4				
		TOTAL	**R**	

B. TOTAL VALUE OF ASSETS SOLD AND DONATIONS MADE OVER THE LAST 5 YEARS (Please specify)

1. **Did you sell or donate any assets (fixed property) during the past five (5) years?**
   If so, please give the following details:

   [a] Assets sold (description) _____
   [i] Date sold _____
   [ii] Bruto amount received R _____
   [iii] Minus selling costs (please specify apart on separate page) R _____
   Netto income _____

   [b] Assets donated (description) _____
   [i] Date donated _____
   [ii] Value R _____

   [c] Cash donated (description) _____
   [i] Date donated _____
   [ii] Amount donated R _____

2. **EXPENDITURE OF A CONTINIOUS NATURE (Documentary proof of expenditure must be furnished) Specify e.g. medical fund, subscription fees, municipal tax, instalments, etc in the case of property:**
   2.1 _____ R _____
   2.2 _____ R _____
   2.3 _____ R _____

   TOTAL R _____

I hereby declare that the information furnished by me, is to the best of my knowledge, true and correct and that the declare income the **total income** of the applicant is for the ..... tax year.

SIGNATURE OF APPLICANT/AUTHORISED PERSON DATE

NB: All interest revenue must be certified per certificate of balance by financial institutions. A false declaration is a punishable offence.

DECLARATION

I certify that, before administering the oath/affirmation, I asked the deponent the following questions and wrote down his/her answers in his/her presence:

[a] Do you know and understand the contents of the declaration?
Answer: _____

[b] Do you have any objection in taking the prescribed oath?
Answer: _____

[c] Do you consider the prescribed oath to be binding on your conscience?
Answer: _____

I certify that the deponent has aknowledged that he/she knows and understands the contents of this declaration which has sworn to/affirmed before me and the deponent's signature/thumb print/mark was placed thereon in my presence.

COMMISIONER OF OATHS

PLACE

DATE

FOR OFFICIAL USE

NETTO INCOME R _____
BOARDING PER MONTH R _____

FOR OFFICIAL USE BY A SCREENING OFFICER OF THE DEPARTMENT OF HEALTH SERVICES AND WELFARE

Gross Income R _____
Minus approved expenditure (specify)
[a] _____ R _____
[b] _____ R _____
[c] _____ R _____
[d] _____ R _____ R _____
Netto Income R _____

Income group code [ ]

OFFICER EMPLOYED BY THE DEPARTMENT OF HEALTH SERVICES AND WELFARE

DATE

11. PRESENT FUNCTIONING

11.1 **Selfcare:**

_____

11.2 **Orientation with regard - one self, other people, environment:**

_____

11.3 **Ability to communicate:**

_____

11.4 **Emotions/Alertness:**

_____

11.5 **Behaviour:**

_____

AGGRESSIVE	PHYSICAL ABUSE	RESTLESS	INCONTINENCY	OTHER

12. PROGNOSIS

_____

_____

13. MEDICATION

_____

_____

_____

14. TREATMENT

_____

_____

_____

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AUTHORITY SIGNATURE DATE

DEPARTMENT OF HEALTH SERVICES AND WELFARE ADMINISTRATION
DEPARTEMENT VAN GESONDHEIDSDIENSTE EN WELSYN ADMINISTRASIE

ASSESSMENT OF THE DEGREE OF PHYSICAL AND MENTAL FRAILTY OF RESIDENTS OF HOMES FOR THE AGED AND HOMES FOR DISABLED PERSONS.

BEOORDELING VAN DIE GRAAD VAN FISIEKE EN GEESTELIKE VERSWAKKING VAN 'N APPLIKANT/INWONER : TEHUIS VIR BEJAARDES OF GESTREMDES

NAME OF RESIDENT:
NAAM VAN INWONER: .....

DATE OF BIRTH:
GEBOORTEDATUM: .....

ASSESSMENT DATE:
EVALUERING DATUM: .....

Select the appropriate statement under each section and enter the applicable point in the block adjacent to th statement. Columns are provided for subsequent evaluations. */Vul die punte van die toepaslike beskrywing in di ooreenstemmende blokkie in.*

	Evaluation / *Beoordeling*			
Points *Punte*	1	2	3	4
0				
2				
3				
4				

1. MOBILITY / BEWEEGLIKHEID

(a) Moves independently, with or without appliances
Beweeg onafhanklik, met of sonder hulpmiddels

(b) Moves with the aid of a walking stick, walking frame/wheelchair with partial support or supervision / *Beweeg met behulp van 'n kierie, loopraam, rolstoel met gedeeltelike hulp of toesig*

(c) Moves only when aided by staff member
Beweeg slegs met behulp van die personeel

(d) Bedridden and totally dependent on assistance. Must be transferred from bed/chair/bed. *Bedlêend en totaal afhanklik van hulp. Moet oorgeplaas word van bed/stoel/bed.*

2. PERSONAL HYGIENE / PERSOONLIKE HIGIENE

2.1 Care of hands, face and feet / *Versorging van hande, gesig en voete*

0				
1				
2				
3				

(a) Completely independent / *Heeltemal selfstandig*

(b) Requires supervision / *Benodig toesig*

(c) Requires assistance e.g. nailcutting / *Benodig hulp bv. knip van naels*

(d) Totally dependent / *Heeltemal afhanklik*

2.2 Oral Care / *Mondsorg*

0				
1				
2				
4				

(a) Completely independent / *Heeltemal selfstandig*

(b) Requires supervision to care for teeth / *Benodig toesig met tandversorging*

(c) Requires assistance with care of teeth / *Benodig hulp met tandversorging*

(d) Totally dependent. Requires care with aid of a mouth tray / *Heeltemal afhanklik. Benodig versorging met behulp van mondbakkie.*

2/.....

	Evaluation *Beoordeling*			
Points *Punte*	1	2	3	4
0				
1				
3				

6. **HEARING / GEHOOR**

(a) Hearing good to reasonable to deaf, but able to function independently *Gehoor goed tot redelik tot doof maar nog in staat om selfstandig te funksioneer*

(b) Hearing poor to deaf. Communicates with difficulty and/or is a disturbance to others / *Gehoor swak tot doof; kommunikeer met moeite en/of is 'n steurnis vir ander*

(c) Hearing poor to deaf - a risk to him/herself and for others / *Gehoor swak of* doof - 'n risiko vir hom/haarself en/of andere

7. **TREATMENT / BEHANDELING**

7.1 Medication / *Medikasie*

0				
1				
3				

(a) Uses medicine independently as and when required / *Gebruik medikasie onafhanklik soos benodig.*

(b) As "a", but monthly control necessary. Medicine must be ordered for resident / *Soos "a" maar maandelikse kontrole nodig. Medisyne moet vir inwoner bestel word*

(c) Medicine is administered, requiring specialized assistance / *Medisyne moet toegedien word. Gespesialiseerde hulp word benodig*

7.2 Care of bed sores / *Versorging van drukplekke*

0				
1				
2				
3				

(a) Not required / *Geen benodig*

(b) At least 3 times a day / *Ten minste 3 keer per dag*

(c) Every 4 hours / *Elke 4 uur*

(d) Every 2 hours / *Elke 2 uur*

8. **TOILET HABITS / TOILET GEWOONTES**

0				
1				
2				
3				
4				

(a) Self sufficient. Complete control of functions / *Selfversorgend. In volle beheer van funksies*

(b) Self sufficient, but experiences problems with stress or mild incontinence. Requires encouragement to practice bladder control. Requires supervision with use of toilet / *Selfversorgend maar ondervind probleme met druklek of geringe inkontinensie. Benodig aanmoediging vir blaasbeheer oefeninge. Benodig toesig met toiletgebruik*

(c) Periodic accidents with no prior preventative measures / *Periodieke ongelukke sonder voorafgaande voorsorgmaatreëls*

(d) Requires catheter and/or colostomy care / *Benodig katerer en/of kolostomie sorg*

(e) Total urine and faecal incontinence / *Totale urien en ontlastingsinkontinensie*

10.5 Comprehension / *Begripsvermoë*

(a) Good ability to follow simple instructions and to understand motives and situations / *Goeie vermoë om eenvoudige opdragte te volg en motiewe en situasies te verstaan*

(b) Able to follow simple instructions, but poor understanding of motives and situations / *In staat om eenvoudige opdragte te volg, maar swak begrip van motiewe en situasies*

(c) Poor ability to follow simple instructions and poor understanding of motives and situations / *Swak vermoë om eenvoudige opdragte te volg en swak* begrip van motiewe en situasies

(d) Unable to follow either simple instructions or understand motives and situations / *Nie in staat om eenvoudige opdragte te volg en motiewe en situasies te begryp nie*

	Evaluation / Beoordeling			
Points *Punte*	1	2	3	4
0				
1				
2				
3				

11 **WORK ABILITY**

(To be completed in respect of non-aged disabled persons only)

(a) Able to work in sheltered employment/open labour market

(b) Able, after instruction, to perform protected work with little supervision

(c) Requires regular supervision to perform protected work

(d) Unable to perform any protected work

0				
1				
2				
3				

TOTAL / *TOTAAL*

KEY TO SCORE / *SLEUTEL TOT PUNTETELLING*		
Points/*Punte*	Care/*Versorging*	Group/*Groep*
0 - 11	Self care / *Selfversorgend*	1
12 - 25	Moderate care / *Matige versorging*	2
26 and over *26 en meer*	*Maximum care / Maksimale versorging*	3

GROUP CLASSIFICATION / *GROEPINDELING*				
Evaluation *Beoordeling*	Group *Groep*	Date *Datum*	Signature *Handtekening*	Capacity *Hoedanigheid*
1st/1ste				
2nd/2de				
3rd/3de				
4th/4de				