ANNEXURE 1

APPLICATION FOR A SUBSIDY
IN RESPECT OF A CLIENT IN RESIDENTIAL / DAY CARE

Name of Institution : _____

Client Surname : _____

First Names : _____

Date of Birth : _____ Gender: M (F) Nationality: _____

Admission Date : _____

Diagnosis : _____

In Receipt of:

a) Disability Grant: Yes / No
Number: _____

b) Care Dependency Grant: Yes / No
Number: _____

c) Other Grant/Pension: Yes / No
Number: _____

e) Trust Fund: Yes / No
Name: _____ Amount: _____

Attached please find the following documentation:

1. Medical Certificate/Report: Yes / No
2. Consent Yes / No (Intellectual disability only)
3. Financial Details Yes / No
4. Social Worker's Report Yes / No (Intellectual disability, residential facility only)
5. Assessment Form Yes / No (Intellectual disability, residential facility only)
6. Assets & Liabilities Yes / No (Adults only)

SUBMITTED BY: Name: _____

SIGNATURE: _____ DESIGNATION:

MEDICAL REPORT ON ADMISSION OF PATIENT BY CONSENT
MENTAL HEALTH ACT, 2002 (SECTIONS 3 AND 4)

NGO/HOSPITAL: .....

Surname : .....

Full name : .....

Age : ..... Date of admission: .....

General physical condition .....

.....

.....

.....

Are there any signs of recent injuries?

Yes	No

If Yes describe .....

.....

.....

.....

Mental condition .....

.....

.....

.....

.....

I, the undersigned being a registered medical practitioner, confirm that the above-named who has been brought to this NGO/Hospital by Mr/Mrs/Miss

.....

a ..... (relationship) is in need of treatment for his/her mental condition.
He/she does not appear to oppose his/her admission to this NGO/Hospital.
His/her mental condition is such that he/she is unable to apply for his/her own admission under Section 3 of the Act.

....
SIGNATURE DATE

.....
QUALIFICATIONS

Clinic Doctor

APPLICATION FOR ADMISSION OF PATIENT BY CONSENT

Ingevolge artikel 4 van die Wet op Geestesgesondheid, 1973, soos gewysig.

In terms of section 4 of the Mental Health Act, 1973 as amended.

EERSTERUST CARE
AND TRAINING CENTRE
(AN ASSOCIATION INC.
UNDER SECTION 21)
Hospitaal/Hospital

Die Superintendent/The Superintendent

Volle naam van persoon ten opsigte van wie aansoek gedoen word
Full name of person for whom application is made .....

.....

Adres
Address .....

.....

.....

.....

Naam van applikant
Name of applicant .....

Adres
Address .....

.....

.....

..... Tel. No .....

Hiermee verklaar ek dat ek die [illegible] (verwantskap) ..... en oud as 18 jaar is, en voen hiermee aansoek om die opname van ..... in bogenoemde hospitaal vir sorg en die behandeling van sy/haar geestestoestand.

Ingevolge artikel 4 van die Wet op Geestesgesondheid, 1973, is ek meegedeel dat genoemde Superintendent die pasient sal ontslaan binne vier dae na my skriftelike kennisgewing van my voorneme om die pasient uit die hospitaal te neem.

*Ek onderneem om die gelde te betaal soos voorgeskryf in artikel 71 en algemene regulasie 15 van die Wet op Geestesgesondheid, 1973 Hiermee doen ek aansoek om vrystelling op grond van die redes uiteengesit in die aangehegte brief.

I hereby declare that I am the a (relationship) ..... and over the age of 18 years, and wish to apply for the admission of ..... to above-named hospital for care and the treatment of his/her mental condition.

In terms of section 4 of the Mental Health Act, 1973, I have been informed that the said superintendent shall discharge the patient within four days of my giving notice in writting of my intention to remove the said patient from this hospital.

*I undertake to pay the fees as prescribed in section 71 and general regulation 15 of the Mental Health Act, 1973/I wish to apply for exemption on grounds as described in the attached letter.

.....
Handtekening van applikant/Signature of applicant

.....
Datum/Date

* Skrap wat nie van toepassing nie.

* Delete whichever is not applicable.

DEPARTMENT OF HEALTH

STATEMENT OF ASSETS AND LIABILITIES

FULL NAMES OF APPLICANT:

_____

DATE OF BIRTH : _____

IDENTITY NUMBER: _____

TOTAL MONTHLY INCOME

SALARY _____

TRUST FUND _____

STATE GRANT _____

PENSION _____

SAVINGS _____

ANNUITIES _____

FIXED PROPERTY _____

SHARES _____

OTHER _____

TOTAL _____

DOES THE APPLICANT HAVE:

FIXED PROPERTY ☐

MOTOR VEHICLE ☐

SIGNED: _____

Parent / Guardian

GAUTENG
DEPARTMENT OF HEALTH

STATEMENT REGARDING PERMANENT RESIDENCE IN RESPECT OF APPLICANT FOR SUBSIDY

FULL NAMES OF APPLICANT:.....

DATE OF BIRTH: .....

IDENTITY NUMBER:.....

APPLICANT'S PERMANENT RESIDENTIAL ADDRESS(es) IN THE PAST TWO YEARS:

.....

.....

.....

I hereby declare that I, ...(name), the undersigned,

am over the age of 18 years and am the .....(relationship)

of the applicant/applicant# whose name appears above.

I hereby confirm that the applicant has/I have#:

- been ordinarily resident in Gauteng Province at the address given above for the past two years;
- not in the past two years been admitted for a period exceeding three months in total to a provincial hospital/other facility in another province;
- not in the past two years been admitted to a hospital in Gauteng as a result of admission procedures initiated in another province.

 # delete where not applicable

SIGNED:.....

DATED THIS .....DAY OF .....20.....

AT .....

COMMISSIONER OF OATHS:

Police

1. I CERTIFY THAT BEFORE ADMINISTERING THE OATH / AFFIRMATION, I ASKED THE DEPONENT THE FOLLOWING QUESTIONS AND WROTE DOWN HIS / HER ANSWER 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: _____

2. I CERTIFY THAT THE DEPONENT HAS AKNOWLEDGED THAT HE / SHE KNOWS AND UNDERSTANDS THE CONTENRS OF THIS DECLARATION WHICH WAS SWORN TO AFFIRMED BEFORE ME AND THE DEPONDENT SIGNATURE, THUMB PRINT, MARK WAS PLACED THEREON IN MY PRESENCE.

COMMISSIONER OF OATHS FOR THE
REPUBLIC OF SOUTH SFRICA

DATED THIS _____ DAY OF _____ 19 ___ AT

_____

Police

GAUTENG PROVINCIAL GOVERNMENT

EVALUATION OF THE DEGREE OF CARE REQUIRED FOR A RESIDENT

NAME: _____

DATE of BIRTH: _____ FILE NO: _____

1. Select the appropriate statement under each section and enter the applicable point for the relevant evaluation number.
2. Points to be allocated are alongside the respective statement.
3. A multi-disciplinary team consisting of a minimum of three persons (one should, if possible, be a therapist) must evaluate each resident, as a team.
4. This evaluation is to be done within seven days of admission and must accompany the application documents

1ST	2ND	3RD	
			1.MOBILITY 0 (a) moves independently 1 (b) moves with the aid of an appliance or needs some assistance 2 (c) moves only with assistance 3 (d) totally dependent and immobile
			2.PERSONAL HYGIENE **2.1. WASHING OF FACE AND HANDS** 0 (a) able to do so independently 1 (b) supervision required 2 (c) assistance required 3 (d) totally dependent
			2.2. BRUSHING TEETH 0 (a) able to do so independently 1 (b) supervision required 2 (c) assistance required 3 (d) totally dependent
			2.3. BATH / SHOWER 0 (a) able to do so independently 1 (b) supervision required 2 (c) assistance required 3 (d) totally dependent
			2.4. BRUSHING HAIR 0 (a) able to do so independently 1 (b) supervision required 2 (c) assistance required 3 (d) totally dependent
			2.5. TOILETING 0 (a) able to use the toilet independently 1 (b) able to use the toilet, but needs assistance 2 (c) able to indicate need to use toilet, but needs a lot of assistance 3 (d) incontinent

3. NUTRITION

0 (a) eats independently
1 (b) supervision required
2 (c) needs assistance
3 (d) needs to be fed

4. DRESSING

0 (a) independent
1 (b) supervision required
2 (c) needs assistance
3 (d) totally dependent

5. VISION

2 (a) partially sighted
3 (b) blind

6. HEARING

2 (a) impaired
3 (b) deaf

7. POSITION CHANGING

7.1. WHEELCHAIR / SEATING SUPPORTS

2 (a) every four hours
3 (b) every two hours

7.2. STRETCHER, MATRESS BOUND RESIDENTS

3 (a) every two hours

8. BEHAVIOUR

8.1. DAMAGE TO SELF e.g. self mutilation, head banging, biting etc

0 (a) never
2 (b) sometimes
3 (c) often / always

8.2. AGGRESSION TO OTHERS

0 (a) never
2 (b) sometimes
3 (c) often / always

8.3 DESTRUCTIVE BEHAVIOUR e,g. breaking things, tearing clothes etc

0 (a) never
2 (b) sometimes
3 (c) often / always

			9. COMMUNICATION 9.1 UNDERSTANDS & FOLLOWS SIMPLE VERBAL/ NON-VERBAL INSTRUCTIONS 1 (a) for most practical purposes 2 (b) to a limited extent 3 (c) not at all 9.2 ABLE TO MAKE NEEDS KNOWN THROUGH VERBAL COMMUNICATION 1 (a) for most practical purposes 2 (b) to a limited extent 3 (c) not at all 9.3 ABLE TO MAKE NEEDS KNOWN THROUGH NON-VERBAL COMMUNICATION 1 (a) for most practical purposes 2 (b) to a limited extent 3 (c) not at all

TOTAL POINTS AWARDED ACCORDING TO SCORE:

0 – 8 Group I
9 – 23 Group II
23 – 35 Group III
36 – 54 Group IV

	GROUP	SIGNATURE	CAPACITY	DATE
1st Assessor				
2nd Assessor				
3rd Assessor				
4th Assessor				

HEAD OF INSTITUTION: J. L Hoods

SIGNATURE: Hoods

DESIGNATION: Manager