KENNERSLEY PARK

Leisure Homes for Senior Citizens

LEISURE HOMES FOR SENIOR CITIZENS

ADMINISTRATION CHECK LIST

Please submit the following documentation on Application:

- Signed Application for Admission letter
- Signed and completed Application Form
- Completed Medical Report (Annexure A)
- Completed Income Declaration (Annexure B)
- Copy of Identification Document of Applicant
- Copy of Identification Document of person signing the Undertaking of Next-of-Kin

Please be advised the following documentation will be requested before Admission process can take place *(This will only be required when a suitable room becomes available and the applicant or family members wish to accept entrance to the Home)*

- Original proof of Residence of person signing the Undertaking of Next-of-Kin and Surety if different (no older than 3 months)
- Identification Document of Surety if different of person signing the Undertaking of Next-of-Kin

The following documentation to be signed before Admission:

- Rules and Regulations
- Agreement of Admission
- Indemnity Form
- Surety Form
- Debit Order Form
- Night Routine Declaration (if applicable)
- Payment of non-refundable Admission Fee R747.50

KENNERSLEY PARK

Leisure Homes for Senior Citizens

APPLICANT NAME: _____

ATT: To Whom It May Concern

RE: APPLICATION FOR ADMISSION

In view of the fact that we receive many enquiries for admission to our Home for persons who, through loss of memory or advanced infirmity are unable to complete and sign the required application form, we have to advise that we are prepared to consider and grant admission in certain special circumstances provided the application is completed by the next-of-kin and signed in front of a Commission of Oaths attesting to the best of his/her knowledge, the information given is true and correct in every detail, and furthermore the next-of-kin undertakes:

1. That the Rules and Regulations for admission to the applicable Home are accepted and that the Company has the right to invoke some or all of the conditions should the occasion arise, and furthermore, that in such an event the signatory will remove the applicant from the applicable Home should the company so require.
2. To accept or appoint a Surety for full and legal responsibility for the accommodation fees (including any increases that may be charged from time to time) during the applicant's residence, and all costs involved in the funeral arrangements of the applicant and to instruct as to the funeral arrangements within twelve hours of the death of the applicant.
3. To attend to all matters relating to the estate of the applicant after death. I, the undersigned, on behalf of the applicant, do accept all the terms and conditions as set out above.

THUS, DONE AND SIGNED In the presence of the undersigned witnesses.

_____ _____

NEXT-OF-KIN WITNESS NAME

DATE: _____

KENNERSLEY PARK

Leisure Homes for Senior Citizens

APPLICATION FORM

IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO ANY SUBSIDISED HOME FOR THE AGED IN THE EAST LONDON AREA.

PLEASE INDICATE YOUR HOME OF PREFERENCE IN NUMERICAL ORDER, AND RETURN THESE FORMS TO THE HOME OF YOUR CHOICE (NO 1) AS INDICATED BELOW:

Kennersley Park | BEACON BAY | Phone: 043 702 5900	
DJ Sobey Home | BUFFALO FLATS | Phone: 043 733 8026	
Fairlands | CAMBRIDGE | Phone: 043 707 2235	

SINGLE ROOM	
SHARED / DOUBLE ROOM	
BEDSITTER	

IMPORTANT NOTICE TO ALL APPLICANTS

Kindly read the attached application forms very carefully before completing.

1. ALL questions must be answered in detail. Incomplete forms cannot be considered.
2. Husband and wife must complete separate forms, but a joint Income and Expenditure form.
3. “The Statement of Income and Expenditure” (Annexure B) must state monthly income, not annual. These Statements must be signed by a Financial Institution of your choice, and in front of a Commissioner of Oaths. Any expenditure of a continuous nature must be supported by documentary proof attached to the form.
4. 'Undertaking of Next-of-Kin' must be signed by a family member or the holder of 'General Power of Attorney' in order to have your application considered.

INTITAL HERE

5. "Medical Report" (Annexure A) must be completed by your Medical Practitioner in as much detail as possible and must accompany your application.
6. Have you been vaccinated for Covid 19? Yes [ ] | No [ ]
7. If yes, please bring your vaccination card with on admission. If no, would you like us to arrange it? Yes [ ] | No [ ]
8. Do you consider your application as urgent? Yes [ ] | No [ ]
9. If yes, please give reasons _____

   _____

   _____

   _____

Once the form has been completed, please phone the Home of your choice, to make an appointment to see the Matron.

Should you have any difficulty in understanding or completing this application, please contact the Home of your choice for clarification.

IMPORTANT: ***Applications will not be considered unless every question is answered in full.***

SURNAME		TEL. #	
FIRST NAME		BIRTH DATE	
CURRENT ADDRESS		IDENTITY #	
MARITIAL STATUS		PREVIOUS JOB	
HOME LANGUAGE		NATIONALITY	
RELIGION		CHURCH	
MINISTER		TEL. #	

INTITAL HERE

MEDICAL: ***(Medical certificate to be completed by Medical Practitioner)***

NAME AND ADDRESS OF YOUR MEDICAL ATTENDANT: _____

_____

Applicants who attend Out-patients must complete the following question so that the Home concerned will know which doctor to call in the event of an afterhours emergency.

FRERE HOSPITAL FOLDER NUMBER	
PRIVATE CHEMIST'S NAME	
MEDICAL AID SOCIETY	
MEDICAL AID NUMBER	

10. **PERSONAL FINANCIAL INFORMATION (See attached Annexure B)**

11. In the event of an emergency/change in medical condition/death, please furnish the names of two contactable persons:

CONTACT 01		TEL. #	
WORK TEL. #		CELL. #	

CONTACT 02		TEL. #	
WORK TEL. #		CELL. #	

IT IS UNDERSTOOD THAT THE ABOVE-MENTIONED PERSONS WILL CONTACT ALL OTHER FAMILY MEMBERS.

INTITAL HERE

DETAILS OF NEXT-OF-KIN:

Names and addresses of all immediate next-of-kin and their spouses are required, as well as their occupations and contact telephone numbers.

FULL NAME			
SPOUSE NAME		CELL. #	
NEXT OF KIN ADDRESS		TEL. #	
		SPOUSE CELL. #	
OCCUPATION		SPOUSE OCCUPATION	
EMAIL ADDRESS			
SPOUSE EMAIL ADDRESS			
RELATIONSHIP			

FULL NAME			
SPOUSE NAME		CELL. #	
NEXT OF KIN ADDRESS		TEL. #	
		SPOUSE CELL. #	
OCCUPATION		SPOUSE OCCUPATION	
EMAIL ADDRESS			
SPOUSE EMAIL ADDRESS			
RELATIONSHIP			

INTITAL HERE

FULL NAME			
SPOUSE NAME		CELL. #	
NEXT OF KIN ADDRESS		TEL. #	
		SPOUSE CELL. #	
OCCUPATION		SPOUSE OCCUPATION	
EMAIL ADDRESS			
SPOUSE EMAIL ADDRESS			
RELATIONSHIP			

NAME AND ADDRESS OF YOUR LEGAL ADVISOR: _____

_____

_____

WHERE IS YOUR ORIGINAL WILL LODGED? _____

_____

_____

POWER OF ATTORNEY: _____

_____

It is a condition of admission that, in the event of you not being able to conduct your own affairs, your Power of Attorney is held by your financial institution, lawyer, or next-of-kin

DO YOU HAVE A FUNERAL POLICY? (If no policy, which Undertakers must be contacted?) _____

_____

INTITAL HERE

FIRM OF UNDERTAKERS: _____

_____

In the event of your death and not having a funeral policy, please state name and address of person responsible for any debts incurred:

FULL NAME	
ADDRESS	
SIGNATURE OF PERSON RESPONSIBLE FOR ANY DEBTS INCURRED	

- I submit the application to the above Home, and once admitted, undertake to comply with the "Rules and Regulations" in operation for the time being, and such alterations as may be made to such rules from time to time.
- I acknowledge receipt of a copy of the "Rules and Regulations" in operation as at the date of signing this agreement.
- I declare that the information given in both this agreement and in Annexure B relating to my monthly income and assets has been accurately and fully stated.
- I promise to pay my monthly accommodation fee in advance, before the first day of each calendar month, which shall be assessed by the Home's Management on the basis of my income and assets as stated in Annexure B, updated annually, and agree to any variation of this charge necessitated by special nursing, other attention, increased income, or any other reason whatsoever.
- I undertake to disclose to the Home's Management any change in my income or my assets immediately the change occurs, and to accept and pay such higher charges as may be determined by the Association.
- I further undertake that if it becomes apparent that I have any income or assets not disclosed in this form or "Statement of Income and Expenditure" Annexure B, or acquire income or assets in the future without declaring same, I will pay, or authorise my Estate to pay, the full economic rate of board and lodging for the period of my residence. (Income from assets disclosed in my Estate shall be assessed at 10% in calculating the board and lodging payable by me for the period of my residence).

INTITAL HERE

- I consent to the Home, if it so desires, drawing my monthly pension, and for this purpose shall sign a Special Power of Attorney, which will be irrevocable whilst I am resident in the Home and will be acted upon at the sole discretion of the Home's Management.

I also note and agree that:

- The Home cannot accept any responsibility for any personal possessions, jewellery, documents, appliances, etc. brought into the Home by the residents, or for any injury sustained by a resident.
- Should the necessity arise for an urgent emergency operation on me, and my next-of-kin is not available, the Matron shall furnish the consent required by the hospital.

How long have you lived in East London or District? _____

_____

Have you ever been resident in this or any other institution for aged or infirm?

Yes [ ] | No [ ] If yes, please give name of institution, date, and reason for leaving:

_____

_____

Due to the present submission formula, relatives will be required to meet the shortfall between the subsidy received and the cost of accommodation, on a monthly basis.

PLEASE NOTE: Transfer from one subsidised Home to another is NOT possible.

_____ _____

APPLICANT SIGNATURE DATE

This form has been signed in my presence and the applicant has declared the foregoing statements to be true and correct.

_____ _____

MAGISTRATE / COMMISIONER OF OATHS / MINISTER OF RELIGION

DATE

INTITAL HERE

UNDERTAKING BY NEXT-OF-KIN

(FULL NAME) _____

IDENTITY NUMBER _____ of (ADDRESS) _____

_____ being the

_____ of the applicant, do hereby contract and undertake to remove the said _____

_____ within a period of 14 (fourteen) days from the date of the request made by the Association if the Association deems such action necessary.

_____ _____

SIGNATURE DATE

INTITAL HERE

ANNEXURE A • MEDICAL REPORT

MEDICAL REPORT TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER IN RESPECT OF AN APPLICATION OF AN APPLICATION FOR ADMISSION TO AN OLD AGE HOME.

Please complete all sections of this form. The information is required to facilitate nursing and administrative arrangements. Unfavorable replies will not exclude the applicant from admission.

FULL NAME	
DATE OF BIRTH	
AGE	

APPLICANT'S HEALTH STATUS (DIAGNOSIS)	

ALLERGIES	

PRESENT MEDICATION & DOSAGE	

INTITAL HERE

OTHER TREATMENT REQUIRED	

GENERAL PHYSICAL & NUTRITIONAL STATE	

RESPITORY SYSTEM | P.T.B	YES		NO	

MEDICATION: CADIOVASCULAR SYSTEM	

BLOOD PRESSURE	YES		NO	

GENITO-URINARY SYSTEM	

INCONTINENCE

YES		NO		PARTIAL	
URINE		STOOLS		BOTH	

URINE TO BE TESTED IN ALL CLASSES	

INTITAL HERE

DIGESTIVE SYSTEM	

DIGESTIVE SYSTEM	
WEIGHT OF PATIENT	

MUSCULAR & SKELETAL SYSTEM	

CENTRAL NERVOUS SYSTEM	*EPILEPSY (please state type, severity & frequency of attacks)*

CEREBROVASCULAR ACCIDENT	

PARKINSON'S DISEASE	

MENTAL CONDITION OF THE PATIENT

NORMAL		MEMORY LOSS		SENILE		CONFUSED		AGGRESSIVE	

INTITAL HERE	

IS THE APPLICANT FREE OF ANY INFECTION OR CONTAGIOUS DISEASES	YES		NO	
IF NO – PLEASE PROVIDE FULL DETAILS				

VISION

GOOD		FAIR		BLIND	
WEAR SPECTACLES		YES		NO	

HEARING

GOOD		FAIR		DEAF	
WEAR HEARING AIDS		YES		NO	

IS THE PATIENT BED-RIDDEN	YES		NO	
IF NO – IS THE PATIENT ABLE TO WALK WITHOUT ASSISTANCE				

IS THE PATIENT IN NEED OF NURSING CARE	YES		NO	
IF NO – WHY DO THEY NEED ADMISSION TO AN OLD AGE HOME				

INTITAL HERE

IF YES – WHAT CARE IS NEEDED

REGULAR		IRREGULAR		CONSTANT	

DOES THE APPLICANT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING:

DRESSING	YES		NO	
DETAILS				

FEEDING	YES		NO	
DETAILS				

PERSONAL HYGIENE	YES		NO	
DETAILS				

HAVE SPECIAL TESTS BEEN CARRIED OUT	YES		NO	

WHICH TESTS HAVE BEEN DONE *(IMPORTANT: PLEASE ATTACH COPIES OF TESTS RESULTS.)*

HOW LONG HAS THE PATIENT BEEN UNDER YOUR CARE	

INTITAL HERE

DEGREE OF DISABLEMENT

SLIGHT		MODERATE		SEVERE	

PROGNOSIS	

ADDITIONAL REMARKS / MOTIVATION FOR ADMISSION	

_____ _____

MEDICAL PRACTITIONER NAME *(Please Print)* SIGNATURE

_____ _____

TELEPHONE #. DATE

_____

ADDRESS

INTITAL HERE

ANNEXURE B

STATEMENT OF INCOME AND EXPENDITURE BY RESIDENTS OF HOMES FOR THE AGED & HOMES FOR THE DISABLED

APPLICANT NAME	

INCOME	**AMOUNT / REF. # IF APPLICABLE**	**MONTHLY INCOME**	
		SELF	**SPOUSE**
Pension Received – Type of Pension			
Annuity – Name of Fund			
Income from Trust Funds and Maintenance Allowances - Name of fund/person			
Shares			

INCOME	AMOUNT / VALUE / REF. #	MONTHLY INCOME	
		SELF	SPOUSE
Director Fees – Name of Company			
Cash Investments – Specify Financial Institution			
Fixed Property – Farm / Dwellings .etc.			
Other Sources of Income – Please specify			

TOTAL INCOME	

INTITAL HERE

TOTAL VALUE OF ASSETS SOLD AND DONATIONS MADE OVER THE LAST 5 YEARS (*please specify*)

ASSETS SOLD		**SELF**	**SPOUSE**
	Date Sold		
	Amount Received		
	Amount for Transfer Duties Paid		

ASSETS DONATED		**SELF**	**SPOUSE**
	Date		
	Value		

CASH DONATED		**SELF**	**SPOUSE**
	Date		
	Value		

INTITAL HERE

EXPENDITURE OF A CONTINUOUS NATURE **(Documentary proof of expenditure must be furnished)** Specify: e.g. Medical fund, medical expenses, tax, subscription fees, bond instalments, etc**.**	**SELF**	**SPOUSE**

I HEREWITH DECLARE THAT THE INFORMATION FURNISHED BY ME, IS TO THE BEST OF MY KNOWLEDGE, TRUE AND CORRECT.

_____ _____

SIGNATURE OF APPLICANT / AUTHORISED PERSON

DATE

I CERTIFY THAT BEFORE ADMINISTERING THE OATH/AFFIRMATION I ASKED THE DEPONENT THE FOLLOWING QUESTIONS AND WROTE HIS/HER ANSWERS IN HIS/HER PRESENCE

- DO YOU KNOW AND UNDERSTAND THE CONTENTS OF THE DECLARATION? ANSWER: _____
- DO YOU HAVE ANY OBJECTION IN TAKING THE PRESCRIBED OATH? ANSWER: _____
- DO YOU CONSIDER THE PRESCRIBED OATH TO BE BINDING ON YOUR CONCIENCE? ANSWER: _____

I CERTIFY THAT THE DEPONENT HAS ACKNOWLEDGED THAT HE/SHE KNOWS AND UNDERSTANDS THE CONTENTS OF THIS DECLARATION WHICH WAS SWORN TO/ AFFIRMED BEFORE ME AND THE DEPONENT'S SIGNATURE/THUMB PRINT/MARK WAS PLACED THEREON IN MY PRESENCE.

_____ _____

SIGNATURE – COMMISSIONER OF OATHS

DATE

_____

PLACE

INTITAL HERE

FOR OFFICIAL USE BY A SCREENING OFFICER OF THE DEPARTMENT OF SOCIAL DEVELOPMENT

GROSS INCOME	**R**
MINUS APPROVED EXPENDITURE (Specify)	
	R
	R
	R
	R
NETT INCOME *The latter amount must be entered on the screening certificate*	**R**

INCOME GROUP CODE	

_____

SIGNATURE – OFFICER EMPLOYED BY THE DEPARTMENT OF SOCIAL DEVELOPMENT

_____

DATE