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ROODEPOORT CENTRE FOR THE AGED

Fundraising nr 055000220000

Private Bag X2
ANSFRERE 1711
TEL: (011) 672 5475 or
087 150 9396
FAX: (011) 472-6194

5 Robinson Avenue
DISCOVERY
1710

INFORMATION REGARDING PROSPECTIVE APPLICANTS:

PLEASE READ CAREFULLY

1. The forms must please be completed fully. Applicants cannot be placed on the waiting list until **all** details have been fully supplied.

2. Please note that it is very important for the applicant to date and sign the enclosure on page 5 of the application form.

3. Each application must please be accompanied by a testimonial from a minister of religion regardless of the denomination to which you belong. One testimonial will be sufficient for a couple who apply.

4. Enclosure B – the medical report or certificate must be completed by a Medical Doctor on the form provided. No other form or letter is acceptable.

5. The Declaration of Income and expenditure (Enclosure D) must be validated by a Commissioner of Oaths. All information will be regarded as confidential. It is however essential that the precise monthly income of the applicant must be clearly stated on the form. Any interest earned from investments must be accompanied by documentation from the concerned place of investment.

6. Should the health of resident's deteriote; they must be willing to be transferred to a section where better care can be given. Enclosure C must therefore be signed by applicant as well as two witnesses.

7. Residents/next of kin are responsible for the purchase of nappies, linen savers, catheters and catheter bags when the resident becomes frail.

8. Applicants or their children residing in the Roodepoort Area will be given preference above other applicants, but all are welcome to apply.

9. A couple must each complete a separate form, but only one testimonial is required for both parties.

10. The Social Worker Mrs.Albertha Oosthuizen must receive the completed forms between 09:00 and 12:00. Kindly phone to make an appointment before returning forms.

11. An Entry Fee is required before admission. Details will be supplied on request. The Entry Fee is a once off payment and is not refundable.

THANK YOU

MRS JOLENE PEYPER
MANAGER

APPLICATION FOR ADMITTANCE TO ROODEPOORT CENTRE FOR THE AGED, ROBINSON AVENUE, DISCOVERY 1710

(TO BE COMPLETED BY APPLICANT OR PERSON AIDING THEM)
N.B. MARK THE QUESTIONS WITH AN X WHERE APPLICABLE.

1. FAMILY NAME (Capital letters) : ……..

2. FIRST NAMES: …….

3. IDENTITY NR: ……

4. PRESENT ADDRESS: ……..

……

ADDRESS DURING THE PAST YEAR ……..

……..

5. PRESENT TEL NR: ……..**.....**

6. GENDER: MALE ……. FEMALE …….

7. DATE OF BIRTH: …….

8. AGE AT LAST BIRTHDAY: ……

.

9. MARRIAGE STATUS: MARRIED: ……..

WIDOWER/WIDOW: ……

SINGLE: ……..

DIVORCED/SEPARATED: ……

10. IF MARRIED, FULL NAME OF SPOUSE: ……

…….

IF WIDOWER, WIDOW, DIVORCED SINCE WHAT DATE? 20…….…….

11. HOME LANGUAGE: …….

12. DENOMINATION: …….

13. FUNERAL UNDERTAKER: ……..

14. NAMES AND ADDRESSES OF ALL LIVING CHILDREN:

14.1 NAME: ……

ADDRESS: ……..

TEL NR: (H) ….……(W)……..

CELL NR: ……E-MAIL: ……..
SON/DAUGHTER

14.2 NAME: ……..

ADDRESS: ……..

TEL NR: (H) ……(W) …….

CELL NR: ……E-MAIL: ……

SON/DAUGHTER

14.3 NAME: …….

ADDRESS: ……..

TEL NR: (H) ……..(W) ……..

CELL NR: …….E-MAIL: ……..

SON/DAUGHTER

(IF MORE NAMES NEED TO BE ADDED KINDLY USE AN EXTRA SHEET OF PAPER.)

15. **WHERE OR WITH WHOM ARE YOU PRESENTLY LIVING:**	YES	NO
WITH A CHILD……	☐	☐
CIRCULATING WITH DIFFERENT CHILDREN …….	☐	☐
WITH OTHER FAMILY MEMBERS …….	☐	☐
WITH SOMEONE BESIDE A FAMILY MEMBER ……...	☐	☐
IN A HOTEL OR BOARDING HOUSE ……	☐	☐
IN AN OLD AGE HOME …….	☐	☐
RUN OWN HOUSEHOLD ……..	☐	☐

16. HOW STRONG ARE YOU PHYSICALLY:

CAN YOU MOVE AROUND OUTSIDE WITHOUT HELP …….	☐	☐
CAN YOU WITHOUT SUPPORT, WALK AROUND IN A BUILDING ..	☐	☐
DO YOU NEED HELP WHEN BATHING ……..	☐	☐
DO YOU NEED HELP WHEN EATING, WASHING OR DRESSING ….	☐	☐

	YES	NO
ARE YOU MOSTLY BEDRIDDEN ……	☐	☐
DO YOU USE A WALKING STICK OR WALKING FRAME …….	☐	☐

17. WAT IS THE PRESENT STATE OF YOUR HEALTH?

IN GENERAL GOOD ……..	☐	☐
VARIABLE OR WEAK ……..	☐	☐
WEAK ……...	☐	☐

18. HAVE YOU ANY AILMENTS OR DISABILITIES FOR INSTANCE:

DIABETES ……	☐	☐
BLINDNESS …….	☐	☐
DEAFNESS – DO YOU WEAR A HEARING AID ……	☐	☐
EPILEPSY ……	☐	☐
HIGH BLOODPRESSURE …….	☐	☐
FORGETFULNESS …….	☐	☐
ASTHMA, CHEST PROBLEMS …….	☐	☐
PORPHYRIA ……	☐	☐

19. ON WHAT MEDICATION ARE YOU PRESENTLY? …….....

……..

20. PREVIOUS ILLNESSES / OPERATIONS: ……

21. ALLERGIES: ……...

22. MEDICAL AID: …….....

23. YOUR PREVIOUS EMPLOYMENT OR OCCUPATION? ……

24. IF PRESENTLY OR PREVIOUSLY MARRIED NAME OF SPOUSE/S MAIN PROFESSION? ……

25. WHAT ARE YOUR INTERESTS / HOBBIES……...

26. WHEN DO YOU WISH TO BE ADMITTED TO CENTRE?

26.1 IMMEDIATELY ……..

26.2 AS SOON AS POSSIBLE ..……..

26.2 LATER ……...

27. SHORTLY STATE THE MOST IMPORTANT REASONS WHY YOU WISH TO BE ADMITTED TO THE CENTRE:

……

……

……

28. STATE CLEARLY WHAT KIND OF ACCOMMODATION YOU REQUIRE :

28.1 FRAIL CARE……

28.2 SINGLE ROOM (FOR HEALTHIER SENIORS) ……..

28.3 DOUBLE ROOM …….

28.4 BACHELOR FLAT ……..

28.5 DOUBLE FLAT ……

IS YOUR TESTIMONIAL ATTACHED: ……..

I HEREBY DECLARE THAT INFORMATION SUPPLIED IN THIS APPLICATION FORM IS ACCURATE AND CORRECT. I UNDERTAKE TO ADHERE STRICTLY TO THE RULES AND REGULATIONS OF THE CENTRE SHOULD I BE ADMITTED AS A RESIDENT.

DATE: ……..

SIGNATURE OF APPLICANT: ……..

ENCLOSURE B

DOCTOR'S REPORT WITH AN APPLICANT FOR ADMISSION TO AN OLD AGE HOME

1. NAME IN FULL: …….....

2. APPLICANT'S AILMENTS (HISTORY, SYMTOMS AND PREVIOUS TREATMENT AS WELL AS HOSPITAL WHERE TREATED.

……

……

3. GENERAL EXAMINATION:

3.1 General physical nutritional condition: ……

3.2 Respiratory system :……

3.2.1 Circulatory system: ……

3.2.2 Blood pressure (must be taken): ……..

3.3 Genital and Urinary system (Urine must be tested)

……..

……..

3.4 Digestive and other Abdominal systems

…….....

3.5 Muscle- and Bone systems (name any defects)

……

3.6 Central nervous system (in the case of epilepsy name kind, degree and how often attacks occur after treatment)

……..

Mental state (including mental deficiency) Name type of abnormality and mental age where possible and whether institutionalisation is required..

……..

3.7 Does applicant have any contagious diseases?

……..

3.8 Any other condition not mentioned above

……

4. 4.1 Is applicant permanently bedridden……

4.2 Is applicant incontinent …….

4.3 Can the applicant be sufficiently cared for by a trained attendant ……..**....**

4.4 Does the applicant need to be dressed and helped with mobility regularly

…….

4.5 Does the applicant need constant and continuous care regarding mobility dressing, feeding and personal hygiene?

…….

5. WILL ANY MEDICAL OR SURGICAL TREATMENT IMPROVE OR CURE THE AILMENTS MENTIONED ABOVE? IF SO, STATE CLEARLY TYPE OF TREATMENT RECOMMENDED.

……

……..

6. PRESENT MEDICATION

……

……

7. ANY FURTHER PERSCRIPTIONS

……..

8. GENERAL REMARK

……

……

……

_____

DOCTOR
(KINDLY STAMP OR PRINT NAME)

PLACE: …….

DATE: …….

DECLARATION BY PROSPECTIVE RESIDENTS

I hereby declare that all information (particularly i.c.w my state of health) is correctly stated in the forms of application and subsequent interviews. I understand that, should it become apparent during the first two months that information was purposefully withheld or was incorrectly stated, I can no longer be accommodated at the Centre.

I understand that all residents in the Healthy Division (i.e. single rooms, double rooms and/or living-units) are obliged to transfer to Frail Care when their health deteriorates and, according to the personnel's judgement, I need to be nursed, I accept that transfer to Frail Care is dependant upon the availability of accommodation and that the Centre cannot guarantee that a bed will be immediately available when the need arises. I realise that it is impossible to immediately obtain a single room in Frail Care and hereby declare that I am willing to share available space. Married couples, that are accommodated in double rooms or living-units, realise that when one of the spouses falls away, the surviving spouse will have to move to single accommodation in order to help some other married couple.

I declare that arrangement proposed has been discussed with my children and/or nearest kin and that they realise the need and accept such arrangement. I accept that, although all movements will be undertaken with great care and consideration, I will be compelled to move whenever, in my own interest, the Management, Personnel and/or my Doctor, recommend it.

1. I undertake to pay promptly on demand all fees owing to Roodepoort Sentrum vir Bejaardes (hereinafter referred as the "Centre") including a non-refundable admission fee. I confirm that I shall enjoy no rights arising from this agreement or any other agreement i.c.w. the Centre unless the Centre possesses a guarantee that covers all of their requirements. The Centre shall have the right at any time before entering into this agreement or during the term thereof to insists upon being favoured with such a guarantee.
2. I undertake to give one calendar month's notice of my intention to leave the Centre and accept that fees paid in advance will not be refundable.
3. I accept that the medical and care facilities provided by the Centre may not be sufficient for my particular needs or for my treatment. I accept furthermore that the Centre's personnel may not be capable or have the necessary qualifications to treat me medically or to care for me. For these reasons I hold the Centre and the Centre's personnel risk free and blameless i.r.o. any disadvantage or damage that I might suffer resulting from the stipulated incapability or inability.

SIGNED : ……..DATE: ……..

WITNESS: 1. …….

WITNESS: 2. ……..