APPLICATION FOR SERVICES IN FACILITY

Complete, scan, and return it by email to fynbosontvangs@gmail.com

EMAIL:

NAME OF FACILITY:

INDICATE THE REQUIRED SERVICE

Room/Shared Room Housing (In Senior Home):

☐ Independent Living ☐ Assisted Living ☐ Frail Care

Rental Apartment/Housing:

☐ Independent Living ☐ Assisted Living

Purchase Living Right:

☐ Independent Living

FULLNAMES:

LASTNAME:

DATE OF BIRTH (dd/mm/yyyy): / /

ID. NO (Choose One Of The Other)

☐ South African ID

☐ Passport

TELEPHONE NO(Own): +

TELEPHONE NO(Spouse/Partner/Child): +

TYPE OF APPLICATION

☐ New Application ☐ Renewal

PHYSICAL ADDRESS:

POSTAL CODE:

GENDER(TICK THE SELECTION):

☐ Male ☐ Female

RACE(TICK THE SELECTION):

☐ Colored
☐ Indian
☐ Black
☐ White

MARITAL STATUS (TICK THE SELECTION):

☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Separated
☐ Other / Prefer Not To Say

HOME LANGUAGE:

RELIGION:

OCCUPATION:

IN THE EVENT OF YOUR PASSING, WHO WILL TAKE RESPONSIBILITY FOR YOUR FUNERAL ARRANGEMENTS AND COSTS?

NAME:

PHONE NO.: +

REFERENCE NO.:

PHYSICAL ADDRESS:

NAME OF HOSPITAL:

FILE NUMBER:

MEDICAL FUND

NAME OF MEDICAL FUND:

NAME OF PLAN:

MEDICAL AID NO.:

DOCTOR'S NAME:

DOCTOR'S PHONE NO.: +

DETAILS OF AL CHILDREN (OR CLOSEST RELATIVES IF NO CHILDREN)

DETAILS 1 (IF APPLICABLE):

FULL NAME:

PHONE NO.: +

CELL NO.: +

EMAIL ADDRESS:

PHYSICAL ADDRESS:

RELATIONSHIP:

OCCUPATION:

DETAILS 2 (IF APPLICABLE):

FULL NAME:

PHONE NO.: +

CELL NO.: +

EMAIL ADDRESS:

PHYSICAL ADDRESS:

RELATIONSHIP:

OCCUPATION:

DETAILS 3 (IF APPLICABLE):

FULL NAME:

PHONE NO.: +

CELL NO.: +

EMAIL ADDRESS:

PHYSICAL ADDRESS:

RELATIONSHIP:

OCCUPATION:

MEDICAL CONDITIONS

WHAT IS YOUR HEALTH STATUS AND WHAT SERVICES DO YOU NEED FROM THE FACILITY?

PLEASE SPECIFY ANY MEDICAL DIAGNOSES (e.g. heart conditions, high blood pressure, chronic illnesses, or congenital conditions)

PLEASE SPECIFY ANY ALLERGIES YOU MAY HAVE:

DO YOU NEED HELP WITH THE FOLLOWING?

- [ ] Mobility (Describe)

- [ ] Bathing/Wash/Eat/Getting Dressed (Describe)

FINANCIAL MANAGEMENT (TICK THE SELECTION)

- [ ] Can Do It Myself
- [ ] Need Help
- [ ] Someone Manages My Finances

If not self, provide the following details (name, contact number and kinship) of the person providing assistance. The person who takes a contract with the finance of the residents and who is contracted with must also complete a financial statement as attached to the application package and bank statements.

FULL NAME:

EMAIL ADDRESS:

PHONE NO.: +

PHYSICAL ADDRESS:

WHEN DO YOU WANT TO BE TAKEN IN?

- [ ] Immediately
- [ ] Within 3 Months
- [ ] Within 6 Months
- [ ] Later

HAVE YOU EVER BEEN ADMITTED TO A CARE FACILITY(TICK THE SELECTION)

- [ ] Yes
- [ ] No

If yes, please insert facility name and contact information below

FACILITY NAME:

FACILITY CONTACT NO.: +

REASON FOR LEAVING THE FACILITY:

THE UNDERSIGNED HEREBY DECLARE:

1. That the information provided in this application form is true and accurate
2. That i will be subject to a survey in the facility, as well as to the Service Level Agreement, House Rules, and regulations, which may be amended from time to time
3. That i have read, understood, and agree to Badisa's Privacy Policy and Terms of use
4. That i consent to the processing of my personal and special personal information in accordance with the Protection of Personal Information Act (POPIA) and Badisa's Policy
5. That i acknowledge and accept the use of cookies as described in the Cookies Policy, where applicable

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NAME AND SURNAME OF APPLICANT/PROXY REPRESENTATIVE:

NAME AND SURNAME (WITNESS)

DATE

/ /