APPLICATION TO SERVICES IN BADISA FACILITY FOR OLDER PERSONS

NAME OF FACILITY: VYGIESHOF OLD AGE HOME

Indicate need for service with an "X":

Room/Shared Room housing
(In Senior Home)

- Assisted Living ☐
- Frail Care ☐

Apartment/Housing

- Assisted Living ☐

1. **SURNAME:** _____
2. **FULL NAMES:** _____
3. **ID.NO:** ☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐
4. **DATE OF BIRTH:** ☐☐ ☐☐ ☐☐
5. **ADDRESS:** _____
   _____

WHERE DO YOU LIVE NOW?

☐ Own Home ☐ Apartment ☐ Children ☐ Hospital
☐ Care Resort ☐ Room/Outside Room/Boarding House ☐ Shelter

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

   TELEPHONE NO: _____ (Code:_____) [Contact Person/child]

   CELLPHONE NO: _____
7. **GENDER:** Male ☐ Female ☐
8. **RACE:** Colored ☐ Indian ☐ Black ☐ White ☐
9. **MARITAL STATUS:** _____
10. **NAME OF LIFE PARTNER:** _____

OR DATE WHEN DECEASED, DIVORCED OR ALIENATED _____

11. HOME LANGUAGE: _____

12. CHURCH INVOLVEMENT: _____

13. PREVIOUS/CURRENT WORK: _____

14. PERSON/INSTITUTION RESPONSIBLE FOR YOUR FUNERAL COSTS:

Name: _____

Address: _____

_____

Tel no: _____

Reference no.: _____

15. NAME OF HOSPITAL AND FILE NO:

_____

16. NAME OF MEDICAL FUND: _____

NAME OF PLAN: _____

Medical Aid Number: _____

Doctor: _____ Tel no: _____

17. DETAILS OF ALL CHILDREN (OR RELATIVES IF NO CHILDREN):

Name	Addresses and Tel no's	Relationship	Career
[1]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		
[2]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		
[3]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		

Name	Addresses and Tel no's	Relationship	Career
[4]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail		
[5]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail		
[6]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		

[Please attach separate list, in case of limited space]

18. WHAT IS YOUR HEALTH STATUS, AND WHAT SERVICES DO YOU NEED FROM THE FACILITY? (ie Care Service, laundry service, meals, cleaning etc.)

_____

_____

Medical Diagnosis (i.e. heart problems, high blood pressure or defects):

_____

_____

_____

_____

Allergies:

_____

_____

Do you need help with the following? (Specify)

☐ Mobility _____

☐ Bathing/wash/eat/getting dressed _____

_____

19. FINANCIAL MANAGEMENT

☐ 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.

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Name: _____

Address: _____

_____

Tel no : _____

20. WHEN DO YOU WANT TO BE TAKEN IN?

Indicate: Immediately ☐

Within 3 months ☐

Within 6 months ☐

Later ☐

21. Have you previously been taken in a home or Care Resort?

-Indicate **yes**, or **no**: .....

- If **yes,** indicate the facility's details/contact information?

_____

_____

.

- Explain what the **reasons** are for leaving the facility:

_____

_____

_____

_____

_.

22. THE UNDERSIGNED HEREBY DECLARE:

- That the information furnished in this application form is true and precise.
- That a survey will be held in the facility at the service level agreement, the House Rules and regulations that may be amended from time to time.

_____

NAME AND SURNAME: APPLICANT/PROXY REPRESENTATIVE

(If the applicant is unable to sign the form)

_____ _____

SIGNATURE OF APPLICANT (OR PROXY/SPONSOR) DATE

_____

NAME AND SURNAME: WITNESS

_____ _____

SIGNATURE OF WITNESS DATE