

APPLICATION TO SERVICES IN BADISA FACILITY FOR OLDER PERSONS

NAME OF FACILITY:

Indicate need for service with an "X":

Room/Shared Room housing
(In Senior Home)

- Independent Living

☐

- Assisted Living

☐

- Frail Care

☐

Apartment/Housing

- Independent Living

☐

- Assisted Living

☐

- Frail Care

☐

Living Right

- Independent Living

☐

- Assisted Living

☐

- Frail Care

☐

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:		

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

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