CPOA
The Retirement Specialist

231 Main Road, Newlands, Cape Town, 7700
+27 (0) 21 686 7830 | info@cpoa.org.za
www.cpoa.co.za
003-044 NPO

STRICTLY PRIVATE AND CONFIDENTIAL

APPLICATION FORM FOR ADMISSION TO:

Please note: (a) All applicants are to complete the form in full.
(b) If a married couple applies, each spouse to complete a separate form.
(c) Please ensure that all the attached documents completed and signed.
(d) Admission is subject to suitability by need, specific criteria and approval by a Selection Committee.
(e) Please ensure that you read and understand Annexure "A" at the back of this form.

1. Full Name:			
2. Present Address:			
		Postal Code:	
3. Telephone No:		Cell Phone No:	
4. E-mail address:			
5. Identity No (ID copy attached):			
6. Nationality:			
7. Date of Birth:			
8. Marital Status:			
8.1 If married, state name of spouse:			
9. Home Language:			
10. Religion:			
11. (a) What was your occupation or profession?			
(b) What is or was your husband's/wife's occupation or profession?			
12. Details of children:			
Name	Age	Address	Present Occupation
13. Name/Address/Tel. No. of next of kin or contact Person:			
14. When do you require accommodation:			
15. Hospital car number:			
16. Please supply the number of your burial society, the monthly premium and whether it is paid up or not:			
17. Who holds this funeral policy:			

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UNDERTAKING BY APPLICANT

(a) I hereby declare that the information furnished by me is, to the best of my knowledge, true and correct.

(b) My full medical history and financial status have, to the best of my knowledge and belief been completely disclosed.

(c) I agree to abide by the requirements set out in Annexure A.

(d) I fully understand that, in the event of my having failed to disclose any information which could have precluded the acceptance of my application, the Organisation shall have the right to terminate my residence on one month's notice.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Witness 1 Signature of Witness 2

UNDERTAKING BY NEXT OF KIN

I, the undersigned _____ (full name),

Hereby accept all the above conditions.

_____ _____

Date Signed

_____

Relationship

ANNEXURE "A"

UNDERTAKING BY APPLICANTS ADMITTED TO CPOA COMPLEXES

If I am admitted to a home/residence under control of the Cape Peninsula Organisation for the Aged, I hereby acknowledge/irrevocably agree:

_____	_____	_____
Date	Signature	Relationship

1. To abide by the Organisation's regulations and household rules and amendments thereto.

2. To pay my monthly board and lodging fees in advance on the first day of each month, the amount of which fees are calculated in accordance with the Organisation's board and lodging policy.

2.1 Should it occur that there are board and lodging shortfalls due by me then, with the Organisation's written approval, these may be accumulated as a debt against my Estate.

2.2 CPOA reserves the right to increase the Board and Lodging tariff on the 1st April each year.

2.3 Any funds belonging to me and given by myself or on my authority to the Organisation to be held in Trust for me may, in the event of my death, be applied towards settling my debts that I may have incurred with the Organisation.

2.4 I/we understand that together with my/our relatives, funeral arrangements and costs are our responsibility. If a funeral policy exists that is not paid-up, we accept that the payment of these monthly premiums must be undertaken by the resident's and/or relatives.

3. Where medical, nursing and paramedical services are not included in the board and lodging tariff of the complex, the resident will be charged for such services.

3.1 In the event of my being admitted to a CPOA complex that does not have a nursing staff complement, I accept that should health problems necessitate the administration of medication that I am prepared to accept this procedure from other staff members.

4. As a permanent resident should I decide to leave the complex, I will give the Organisation two calendar months' notice in writing, or pay the Organisation two months' board and lodging in lieu of notice. Should I pass away while resident in the CPOA complex, an administration fee equivalent to one month's full board and lodging will become payable from my Estate.

5. That the Organisation reserves the right and at its sole discretion to transfer me from within a complex from one room/ward to another or from one complex to another under its control. I accept that the Organisation has the right to implement such a transfer if in its sole opinion my circumstances, including health and financial status, indicate that it is necessary or desirable. Furthermore, I acknowledge that the board and lodging charge may be increased or decreased in accordance with the scale of charges pertaining to my new accommodation and services rendered.

6. That the Organisation does not accept responsibility for any personal possessions, jewellery, documents, appliances, etc. brought into the complex by me and that I am responsible for the insurance of such items.

7. That should I require a wheelchair, I will purchase or hire same and maintain it in good condition at my expense.

8. CPOA reserves the right to refer residents for assessment by medical professionals.

9. That should the need arise for any emergency operation to me and my next-of-kin is not available, the manager of the complex or his/her nominee may furnish the consent required by the medical authorities.

10. CPOA reserves the right to give notice to residents who exhibit anti-social behaviour, with the care of the resident becoming the relative's responsibility.

11. CPOA is not responsible for Medical Aid claims. This is the responsibility of the family.

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ADDENDUM

Any other pertinent information:

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ANNEXURE "A"

THIS FORM IS TO BE RETAINED BY THE APPLICANT AND / OR NEXT OF KIN

UNDERTAKING BY APPLICANTS ADMITTED TO CPOA COMPLEXES

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Date	Signature	Relationship

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ANNEXURE "B"

STATEMENT OF INCOME AND EXPENDITURE

INCOME	
Source of Income	**Amount**
A) Type of Pension and number	
1.	
2.	
3.	
B) Spouses pension and number	
1.	
2.	
C) Other income (i.e. Annuity\Cash investments)	
1.	
2.	
3.	
D) Revenue from Property	
1.	
2.	
TOTAL INCOME:	
EXPENDITURE	
1. Medical Aid	
2. Burial Insurance	
3. Other Expenditures (Not telephone, electricity or food)	
TOTAL EXPENDITURE:	
MONTHYL INCOME:	

Account No: | | | | | | | | | | | |

Branch: | | | | | | | | |

_____

Signature of applicant or delegated person

Commissioner of Oaths:

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ANNEXURE "B"

STATEMENT OF INCOME AND EXPENDITURE

INCOME	
Source of Income	**Amount**
TOTAL INCOME:	
EXPENDITURE	
TOTAL EXPENDITURE:	
MONTHYL INCOME:	

Account No: | | | | | | | | | | | |

Branch: | | | | | | | | |

_____

Signature

Commissioner of Oaths:

_____

Print Name

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DEED OF SURETYSHIP

I / We the undermentioned / undersigned

SURNAME:_____ FORENAMES: _____

I.D. NO.: _____

RESIDENTIAL ADDRESS: _____ CODE _____

POSTAL ADDRESS: _____ CODE _____

TEL: (home) _____ (work) _____ (cell) _____ E-MAIL:_____

OCCUPATION / PROFESSION: _____

EMPLOYER'S NAME & ADDRESS: _____ CODE _____

E-MAIL_____ FAX _____ TEL _____

Should you be married in Community of Property, please complete section below.

SPOUSE SURNAME: _____ FORENAMES: _____

I.D. NO.: _____

WORK ADDRESS: _____ CODE _____

CELL: _____ E-MAIL _____

Please provide:

1. Proof of residency, i.e. copy of telephone bill or rates statement
2. Copy of latest pay slip and bank statement.
3. Statement of assets – fixed deposits, house, car and liabilities.

I do hereby guarantee and bind myself / ourselves jointly, severally and in solidum to CAPE PENINSULA ORGANISATION FOR THE AGED as Surety / Sureties in solidum for and co-principal/s with

RESIDENTS NAME & SURNAME: _____

RELATIONSHIP: _____ Home-Residence _____

for the due and punctual payment (by the 1st of each month) to CAPE PENINSULA ORGANISATION FOR THE AGED of any amounts which debtor may now or in the future owe to CPOA in respect of board and lodging, or any other indebtedness (i.e. pocket money, room service, guest meals etc.). In the event that no payment is made, CPOA reserves the right to move or give notice to the resident and to hand the surety over to the Attorneys.

It is AGREED that this Suretyship shall remain in force as a continuing security notwithstanding any fluctuations in the amount due by the debtor (agreed amount is subject to an annual increase).

DATED AT _____ THIS _____ DAY OF _____ 20 _____

SURETY: _____ DATE: _____

SPOUSE: _____ DATE: _____

AS WITNESSES: 1. _____ 2. _____

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ACKNOWLEDGEMENT OF DEBT

I……, do hereby acknowledge

1) my responsibility to ensure that any recurring or intermittent accounts are paid timeously and that failure in this regard will result in legal action being taken by CAPE PENINSULA ORGANISATION FOR THE AGED to recover amounts owed.

2) the right of CAPE PENINSULA ORGANISATION FOR THE AGED on my death to apply to my estate for payment of any amount which may be due to CPOA.

Dated at …….. this the …….. day of …… 20…..

_____

Signature of Debt Holder

AS WITNESSES:

1._____

2. _____

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PSYCHIATRIC REPORT

(if required and requested by Nursing Manager**)**

Name
Age

Mental Condition

1. Schizophrenia, including hallucinations			9. Intellectual Disability		
Schizophrenia, including delusions\					
paranoid ideas.			10. Drug Abuse		
Outward manifestations:					
			11. Present functioning		
			Personal Hygiene		
			Mobility		
2. Anxiety States			*Orientation to changes*		
Psychosomatic			*Ability to Communicate*		
Obsessive-compulsive			*Emotions\Alertness*		
Hysteria			*Behaviour*		
Phobias			**Aggressive**		
Outward manifestations:			**Abusive**		
			Wanders around		
			Incontinent		
			Other		
4. Depressions					
Reactive\mild					
Endogenous\severe			12. Prognosis		
Manic-depressive psychosis					
Suicidal					
5. Acute disorders of delirium\confusion states					
Chronic dementia					
Degree			13. Medication		
6. Personality disorders					
Passive dependent					
Passive Aggressive					
			14. Treatment		
7. Drinking problems					
Socially					
Chronic					
Brain Damage					
8. Epilepsy					
Controlled on medication?	Yes	No			
Remarks					

DATE: _____NAME_____SIGNATURE _____

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MEDICAL CERTIFICATE IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO HOMES FOR THE AGED

(To be completed by a Medical Practitioner or District Surgeon)

N.B.: Replies to all questions are required to facilitate nursing and administrative arrangements.

1. SURNAME OF APPLICANT: _____ FIRST NAME(S): _____
(In Block Letters)

2. APPLICANT'S COMPLAINTS (HISTORY, SYMPTOMS & PREVIOUS TREATMENT - STATE HOSPITAL WHERE TREATED):
(Please Print)

   Medical: _____

   Surgical: _____

   Psychiatric: _____

3. GENERAL EXAMINATIONS:

   a) General physical and nutritional state _____ Temp: _____

      i) Weight/Mass: _____ ii) Appetite: _____

   b) Respiratory system _____

   c) Cardio-vascular system _____ Pulse: _____

      Hb: _____ B/P: _____

   d) Genito-urinary system _____

      Dysuria: _____ Urine test results: _____

   e) i) Gastro-intestinal system _____

      ii) Hernia _____

   f) Masculor-skeletal system: Does the applicant suffer from? (Please delete terms not applicable)

      i) Osteoporosis _____

      ii) Osteoarthritis _____

      iii) Rheumatoid arthritis _____

      iv) Locomotive disabilities _____

      v) Hemiplegia _____

      vi) Myopathies _____

   g) 1. Central nervous system _____

      1.1 Tremors _____

      1.2 Parkinson's _____ Multiple Sclerosis: _____ Motor Neurone: _____

      2. Neuropsychiatric _____ Other: _____

   h) Endocrine system _____ HGT: _____

   i) Ear, nose and throat _____

   i) Eyes _____

      i) Vision levels _____

ii) Spectacles / contact lenses / implants _____

j) Does the applicant suffer from any disease of the skin? (Include bedsores, ulcers, etc.) _____

_____

4. a) Degree of mobility _____

b) Is the applicant incontinent? Type: _____ Urine: _____ Faeces: _____

c) i) Has the applicant any communicable disease? (e.g. TB)

ii) Current treatment _____

d) i) Presence or suspicion of neoplasm, tumours? _____

ii) Treatment regime? _____

e) Has the applicant any known allergies or sensitivities? (If so, please detail) _____

f) Has the applicant any history of alcohol or drug dependency? (If so, please detail) _____ Smoker: Y / N

g) Dentition: _____ Caries: _____ Dentures: _____

h) i) Is the applicant's hearing: GOOD _____ PARTIALLY DEAF _____ DEAF _____ (Please tick appropriate box)

ii) Hearing aid use: Yes / No

i) Does the applicant require:

i) Regular assistance in respect of mobility, personal hygiene, medication and dressing or undressing? _____

_____

ii) Constant and prolonged assistance regarding mobility, dressing or undressing, feeding and personal hygiene? _____

_____

j) What is the applicant's mental condition?_____ Mini-mental test result _____
(Please tick if one or more are applicable)

a) i) Normal _____ iv) Restlessness _____

ii) Depression _____ v) Insomnia _____

iii) Senile Dementia _____ vi) Anxiety _____

iv) Abusive and/or aggressive/violent _____

v) Behaviour Disorder _____

vi) Psychosis _____

b) i) Does the applicant have reasonable recall of recent events? _____

ii) Is applicant fully time-and-place orientated? _____

iii) Has the applicant any history of wandering from home? _____

5. HOW LONG HAVE YOU BEEN IN ATTENDANCE ON APPLICANT? (IF FIRST VISIT, NAME OF USUAL MEDICAL DOCTOR, DAY HOSPITAL CARD NUMBER IF APPLICABLE):

_____

6. FURNISH DETAILS OF ALL CURRENT MEDICATION: _____

_____

i) Please indicate signs to be watched for in respect of re-evaluation _____

_____

ii) Follow-up dates for tests, surgery, and repeat prescriptions _____

_____

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7. GENERAL REMARKS: _____

_____

_____

_____

_____

Place: _____ **Date**: _____

Signed: _____ **General Practitioner/District Surgeon**

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DEBIT ORDER INSTRUCTION FORM

Name of Bank: _____

Branch Name: _____

Branch Number: | | | | | | | | |

Type of Account: Current (Cheque)\ Savings

Account No: | | | | | | | | | | | |

I\We hereby request, "instruct" and authorise the Cape Peninsula Organisation for the Aged to draw against my\our account with the abovementioned bank (or any other bank or branch to which I\we may transfer my\our account) the amount necessary for payment of the monthly amount due in respect of Board and Lodging\Levies and additional sundry expenses (for example Meals, room service, garage rentals etc.) on the FIRST day of each and every month. All such withdrawals from my\our account by CPOA shall be treated as though they had been signed by me\us personally.

I\We understand that the withdrawals hereby authorised will be processed by computer through a system known as the ACB Magnetic Tape Service, and I\We also understand that details of each withdrawal will be printed on my\our bank statement or on an accompanying voucher.

I\We agree to pay any bank charges relating to this debit order instruction.

This authority may be cancelled by me\us by giving CPOA thirty days notice in writing, sent by prepaid registered post, but I\we understand that I\we shall not be entitled to any refund of amounts which CPOA has withdrawn while this authority was in force if such amounts were legally owing to CPOA.

Receipt of this instruction by CPOA shall be regarded as receipt thereof by my\our bank (whichever it is or will be).

ASSIGNMENT:

I\We acknowledge that the party hereby authorised to effect the drawing(s) against my\our account may not cede or assign any of its rights to any third party without my\our prior written consent and that I\we may not delegate any of my\our obligations in terms of this contract\authority to any third party without prior written consent of the authorised party.

Name:_____Home\Residence_____Ref. No._____

Signed_____on this_____day of_____20

_____
Signature as used for signing of cheques

_____ _____
Assisted by (where legally necessary) Capacity

Note: A cancelled cheque must be attached for bank identification purposes (Current accounts only).