

Dear Applicant

ADMINISTRATION FEE FOR PROCESSING OF ENCLOSED APPLICATION

A once-off Administration Fee of R150.00 is required before your application can be processed.

This fee also covers the home visit assessment of the Occupational Therapist and Senior Social Worker, followed by the preparations for the Admissions Committee, which involves various staff in the Finance and Administration Department.

Kindly enclose a cheque for the above mentioned amount, made payable to Highlands House, when you return these forms, duly completed.

Yours faithfully

MANAGEMENT
HIGHLANDS HOUSE

ADMISSION PROCEDURE

The following is a step-by-step guide to the procedure which is followed for all applications to Highlands House. In order to speed up the process, please ensure that the forms are completed in full and that any instructions are followed up promptly on your side.

We will do our best to process the application and effect admission as speedily as possible. **The application procedure is co-ordinated by the Social Work Department. Please direct any queries to the department.**

1. The attached set of **application forms must be returned**, fully completed, **to the Social Work Department**. Please supply the names and phone numbers of all family members who are significant to the applicant.
2. On receipt of the fully completed forms a home visit will be conducted, the applicant and/or family member will be telephoned and an appointment set up.
3. The **tariff** will be determined after the assessment is done, using the Resident's Care Rating Scale. This tariff will be communicated to the resident and/or family member. An appointment to discuss fees payable and related financial issues needs to be made. Please contact the secretary in the Directorate.
4. An agreement will be reached on the nature of the payments to be made and the agreement must be confirmed at an **Admissions Meeting**.
5. The family will be informed of the **date and time of the Admissions Meeting** to be attended.
6. Papers need to be submitted to the **Department of Social Services** for their approval – this normally takes at least one week.
7. Hereafter, the applicant will be **offered accommodation** once it becomes available. Please note that it may be necessary to wait for a suitable room for the specific person as we tend to be fully occupied due to a continuous demand for accommodation.

Kindly complete the relevant documentation. You will be contacted upon receipt of the completed Application Forms.

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APPLICATION FOR RESIDENCE IN HIGHLANDS HOUSE

Applicant's Personal Details

Surname:	Maiden Name:	
First Names:	Prof/Dr/Mr/Mrs/Miss:	
Hebrew names:	Father's Hebrew Name:	
Date of birth:	Present age:	Place of birth:
Present Address:		
Telephone:	ID. No:	
Are you living in your own home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If not, where and with whom are you living?		
Pension type:	Pension no:	
Previous occupation:	Level of education:	
Name of Present House Doctor (GP):	Telephone:	
Name of Doctor who will attend in Highlands House:		
Name of Medical Aid/Insurance:	Membership No:	
Emergency contact person:	Tel:(w)	(h)
Name of attorney:		
Address:		
Name of Accountant:		
Address:		
Have you made out a will?	Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, name the executor:
Are you a member of a synagogue?		
If not, are you Orthodox or Reform:		
Do you require any special burial arrangement?		
If yes, please specify:		
<p>APPLICANTS ARE REQUESTED TO SUPPLY 4 PASSPORT-SIZE PHOTOGRAPHS WITH THE APPLICATION PLUS A COPY OF ID DOCUMENT & MEDICAL AID CARD</p>		

Particulars of Family

SPOUSE			
Name:			
Previous occupation:			
Date of marriage:			
In/Out of Community of Property (delete where applicable):			
If divorced, date of divorce:			
If deceased, date of death:			
SUPPORT SYSTEM			
Please give details of your children, relatives (local and overseas) and Friends			
Name:	Address:	Occupation:	Contact details: Tel (h): Tel (w):
Relationship:		Spouse's occupation/ business:	Cell: Fax: Email:
Name:	Address:	Occupation:	Contact details: Tel (h): Tel (w):
Relationship:		Spouse's Occupation/business:	Cell: Fax: Email:
Name:	Address:	Occupational	Contact details: Tel (h): Tel (w):
Relationship:		Spouse's Occupation/business:	Cell: Fax: Email:
Name:	Address:	Occupational	Contact details: Tel (h): Tel (w):
Relationship:		Spouse's occupation/ business:	

RULES AND REGULATIONS OF HIGHLANDS HOUSE

A signed copy is to be returned with the application.

Please retain the second copy.

1. The Paramedical Assessment Committee under the chairmanship of the Honorary Medical Superintendent will place a resident according to his/her care needs. These decisions will be discussed with the resident and/or the family, supported by medical opinions if queries exist.
2. The fee applicable to a resident is determined in accordance with Rule 1. Fees are adjusted annually in January of each year or should the care requirement change during the course of the year.
3. A once-off administration fee is charged on admission.
4. It is a requirement of the Department of Social Services that residents submit a declaration of their income in April of each year.
5. Should you wish to leave Highlands House, one calendar month's notice must be given in writing.
6. The Home may, after notice to the resident and the resident's nominee, terminate the resident's right of residence and require the resident to vacate Highlands House forthwith under the following circumstances should such conduct persist. Where the resident:
 - Is guilty of a serious contravention of the rules and regulations relating to the Home;
 - Behaves in such a way as to disturb the peace of the other residents;
 - Unreasonably infringes upon the enjoyment and rights of the other residents;
 - Interferes with the management of the residence and the provision of service in the residence
7. Residents intending to be away from the Home either overnight or longer must inform the Nursing Management. Where indicated, medical approval may be required. Residents will be given sufficient medication for the visit.
8. All clothing and furniture brought into the Home must be clearly marked to prevent losses. The Home cannot take responsibility for clothing which is not clearly marked. An inventory will be drawn up on admission. Additional items must be recorded in the resident's inventory. Residents who intend bring in items of furniture (including refrigerator and TV) must bring these items to the Home 3 days prior to admission (excluding weekends and Jewish Holidays) for fumigation purposes. Telephones may be organised by the Home but a lock is strongly recommended to prevent unauthorised use.
9. Any clothes sent for dry cleaning by the Home will be charged for accordingly. There is no charge for laundry.
10. In the event of any jewellery and/or other valuables being brought into the Home, no responsibility shall be accepted by the Home. These articles should be left in safekeeping with relatives.

ATM cards and credit cards are a ready source of cash and the Home does not recommend that residents retain these cards. The Home accepts no responsibility for these items or any transactions carried out through these means.

It is recommended that residents keep only a small amount of cash (+- R10.) in their room. Money can be kept in safe-keeping at our bank in resident's Trust Account and drawn when needed.

11. Residents and visitors are requested to adhere to security regulations. Signing in the waived only on Shabbat and Yom Tov. Bags are subject to search.
12. A R50.00 cash key-deposit will be payable for cupboard and/or door keys. In consultation with the Paramedical Assessment Committee, a resident may be allowed a key to lock his/her room from the outside only.
13. Electrical appliances, i.e. kettles, toasters, heaters, are not allowed in the resident's rooms. Boiling water is available from the floor kitchen for tea and coffee.
14. Only the Nursing Manager, Sisters or Staff Nurse may call a doctor to attend to a residents or order medications. If a resident takes any medicines other than those prescribed by his/her regular physician, the trained nursing staff must be notified. Complications may result which can have serious effects.
15. No tips, presents or loans are permitted to be given to any members of the staff.
16. The resident agrees that the representative nominated in this application form shall be his/her nominee from whom any instructions may be taken or to whom any notice in terms of the agreement may be given, where, in the opinion of the Management Committee of Highlands House, it appears that the resident is not able to manage his/her own affairs or to form an intention to express his/her own will. In such a case, any notice given to the nominee or any instructions received from the nominee shall be deemed to be a notice or instructions from the residents.
17. The engagement of private specials are subject to guidelines and must be approved by nursing management.
18. Highlands House can only arrange transport to medical appointments where no family is available to assist. Family will always be approached in this regard. A fee will be levied if the Home's transport is used.
19. It is the family's responsibility to inform both care staff and the administrative department of any changes in address, home or work telephone numbers.
20. Only Beth Din kosher foodstuffs may be brought into the Home, for staff and residents alike.

I acknowledged that the Management Committee may from time to time rules and regulations relating to the Home and I agree to abide by those rules and regulations. I agree to abide by the house rules set out above.

.....
Signature

.....
Date

HIGHLANDS HOUSE MEDICAL ADMISSION ASSESSMENT RECORD

Date of Assessment / /

First Name		Middle Name		Last Name			
Id. No.			DOB	/	/	Age	Gender
Reason for Admission (tick all that apply)							
Physically frail		Rehabilitative care		Behavioural disturbance			
Cognitive impairment		Palliative care		Assistance with basic ADL's			
Urinary continence		Respite care		Psychiatric illness			
Recurrent falls		Post surgical care		Socially isolated			
Other:							

Medical & Surgical History		
	Problem	Date diagnosed
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		
13)		
14)		
15)		
16)		
17)		
18)		
19)		
20)		

Current Medication (include all OTC's, multivitamins, laxatives, herbal preparations, etc.)			
Item (name, dosage form, strength, frequency of admin and instructions)	Illness Condition	Date commenced	Chronic/Acute
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

Medication stopped due to side effects, lack of efficacy, allergies, intolerances		
Item	Date Stopped	Reason Stopped
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Healthcare Professionals Consulted in Past 5 Years			
Name	Discipline	Date	Active/Inactive
1)			
2)			
3)			
4)			
5)			
6)			

During the past 2 weeks has the person required assistance with any of the following								
Item	Y	N	Item	Y	N	Item	Y	N
Feeding & drinking			Grooming			Toileting		
Dressing			Transferring into/out of bed			Washing/bathing		
Walking unassisted			Conversing/communicating			Administering medication		

During the past 4 weeks has the person had any of the following								
Item	Y	N	Item	Y	N	Item	Y	N
Delusions			Depression			Apathy		
Hallucinations			Anxiety			Disinhibition / sexual impropriety		
Agitation / Aggression			Elation / euphoria			Fluctuation in mood / irritability		
Pacing/opening closing drawers			Alteration in sleep / wake cycle			Eating disorders		
Fall			Hospitalisation			Head injury		

Social history									
Item	Y	N	Quantity	Item	Y	N	Item	Y	N
Drink alcohol				Drive a vehicle					
Smoke cigarettes				Participates in social activities e.g. playing cards, community activities, synagogue, family affairs etc.					

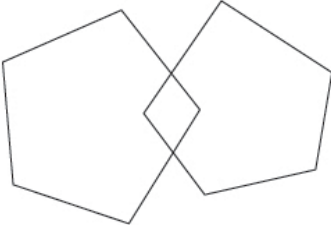
Screening Tests & Special Investigations Undertaken (please include others e.g. CT / MRI / SPECT if available)									
Item	Y	N	Date	Result	Item	Y	N	Date	Result
Weight					FBC				
Height					U/E/Creat				
BP					Glucose				
Flu Vaccine					TSH				
Pneumovax					Lipogram				
ECG					PSA				
Hearing Test					Chest X Ray				
Eye Test					Mammogram				
MMSE					Dexa BMD				
Lung Function					Colonoscopy				
Pacemaker					Gastroscopy				

FOLSTEIN'S MINI-MENTAL STATE EXAMINATION (MMSE)

TO BE COMPLETED BY A MEDICAL PRACTITIONER. PLEASE PRINT

PREAMBLE AND INSTRUCTIONS FOR ADMINISTERING THE MMSE

Tell the patient that you are going to ask some questions and that you will be glad if he/she will help by answering them. In case of highly intelligent patients say that you realise that the questions may seem very easy but that for health screening purposes we do need to include all patients. Note that this test should only be administered to patients who are alert. For questions 6, 7, 8, 9, 10 and 11, patients with significantly impaired eyesight or deafness should be scored 'E of D'

Name of patient:			Date:					
	Possible points	Score		Possible points	Score			
1. What is this year?	1		7. Tell patient ' I am going to say something once and then I want you to repeat it '. Then say ' No ifs, ands or buts '. (Take care to pronounce the final s's clearly and penalise if the patient omits them).	1				
What is this season?	1							
What is the month?	1							
What is the date?	1							
What day of the week is this?	1		8. Ask patient to follow this three stage command. ' Take this paper in your right hand. Fold the paper in half. Put the paper on the floor '. Then hand patient the paper. (Penalise if the patient folds the paper more than once).	3				
2. In which country are we?	1							
In which province are we?	1							
In which town or city are we?	1							
In which hospital/building are we?	1							
In which floor/clinic/ward are we?	1		9. Ask patient to read and obey the instruction printed below. (Close your eyes).	1				
3. Tell the patient: " I am going to say three words which I want you to remember ". Then say (only once) " apple, pen, table ", taking one second for each. Then ask the patient to repeat all three. Score one point for each correct answer. Then say: " Later I am going to ask you to repeat these words ".	3					10. Ask patient to write a sentence of own choice. (The sentence should contain a subject and a verb and be sensible. Ignore spelling errors when scoring).	1	
CLOSE YOUR EYES								
4b. Ask patient 'Spell WORLD'. Correct any errors and rehearse until patient spells correctly. Then ask patient ' Now spell WORLD backwards '. Score one point for each letter correctly placed and enter score. (maximum 5 in box, e.g. DLORW=3; DWR=2)	5	Best of 4a & 4b						
5. Ask patient ' Please repeat the three words that I asked you to remember ' (as in question 3). Score one point for each correct answer.	3		Total Score: Maximum 30					
			Age: _____ Years of schooling Able to read: YES/NO Able to hear: YES/NO Scoring: For a person with 7 years schooling, good eyesight and hearing, a score of less than 24/30 is highly suggestive of dementia or delirium. Where illiteracy or eyesight is relevant the score is expressed as x/30-y (where y is the number of disqualified questions and x the number of correct answers)					
6. Point to a pen and a watch . Ask patient to name them as you point.	2							

Doctor's Details and signature (to be completed by doctor)

I Dr. _____ declare that the

patient _____ was examined by myself and all information pertaining to the patient is true to my fullest knowledge.

Signed at _____ this _____ day of _____ 20 ____.

Signature of Doctor _____ Qualifications _____ HPCSA No. _____

Address _____

Who will be the patient's designated doctor at Highlands House?

FORM OF CONSENT

1. As there is a risk of a resident passing on an infectious disease to a health care worker employed by this Home, I, the resident, hereby consent to be tested for any suspected infectious disease including HIV virus should the Home in its sole discretion believe it to be in its own interest.
2. The results of any test shall remain confidential as between doctor and patient.

Name (print please):

Signature:

Date:.....

Witness (please print):

Signature:

Date:

FINANCE

Declaration and Undertaking

I,

Being (THE APPLICANT OR AUTHORISED PERSON)

hereby declare that the data furnished in this application form is to the best of my knowledge true and correct.

I furthermore acknowledge that:

1. with regards to this application Highlands House reserves the right to amend or withdraw any financial assistance granted, and to recover any assistance previously granted should any information submitted in Annexure B attached hereto be found to be false;
2. I have read the Rules and Regulations of Highlands House and agree to abide by them (if I become a resident of the Home);
3. whilst the utmost care is exercised and trained staff are always on duty, Highlands House does not accept liability for any injury to a resident.

In the event of an emergency, the Matron or authorised person may authorise treatment or hospitalisation. The Home does not accept liability or responsibility.

Signature of applicant or representative

RelationshipDate

State under which authorised and date (COPY OF DOCUMENT TO BE ATTACHED)

.....

KINDLY ENCLOSE A COPY OF THE LATEST TAX RETURN OF THE APPLICANT

WHEN YOU SUBMIT THESE FORMS.

THANK YOU.

TO BE COMPLETED BY ADMISSIONS COMMITTEE

The fee (plus surcharge imposed by the State the State, e.g. VAT) determined in accordance with the applicant's care requirements (Group) has been assessed as Rper month.

It has been agreed that the applicant shall pay:

1. The full fee of R.....per month, or
2. Rper month
Contributions by individual family members towards any shortfall in the monthly fee will be covered by specific signed undertakings.
3. An amount of Rper month will be put to a deferred account, secured by a signed pledge of Rin favour of Highlands House.

Dated a Cape Town thisday of20

SIGNATURES

Applicants or responsible authorityRelationship.....

Chairman, Admissions Committee.....

Witness

Committee member

Accounts to be sent to:.....

.....

.....

.....

.....

MONTHLY EXPENDITURE

This form is to be completed by an applicant requesting a reduced monthly fee.

Rent/bond/board and longing	R
Water, lights and rates	R
Telephone	R
Domestic Worker's salary	R
Transport	R
Food/cleaning materials and incidentals	R
Clothing	R
Hire purchase (monthly)	R
Insurance (monthly): household/other	R
Medical Aid	R
Medical Expenses not covered by medical aid	R
M-Net/satellite	R
Interest on bank loan/overdraft/credit card	R
Bank charges	R
Any other commitments	R
TOTAL EXPENSES	R
SHORTFALL IN BUDGET	R

CONDITIONS PERTAINING TO ACCOMMODATION

1. Should at any time during my stay in my room I become physically incapacitated to the extent that the Home is unable to provide the level of care that I require, I will be required to vacate the room and move to a section in the Home where the correct care can be given to me.
2. Should at any time during my stay in my room I become mentally frail to the extent that I am unable to function at the level as set out as defined by Highlands House, for residents in specific areas, I understand that I will have to vacate my room and move to a section in the Home where the correct care can be given to me.
3. The provision of extra nursing care (a special) will in no way be accepted as an alternative to moving as the move is being made because I no longer fit the criteria of my room.
4. Should I have to vacate my room and move to a section of the Home where the correct care can be given to me, I understand that I will have to pay for all costs involved in a room transfer. eg. Telephone transfer, television installation. I accept that these costs will be for my account.

I accept that Highlands House’s inter-disciplinary team together with the Home’s Medical Sub-Committee, will be the final arbiters in regard to the necessity for me to move should the need arise.

I understand clearly and accept that Highlands House will not have to pursue any formal procedure to enforce its rights as mentioned in paragraphs 1 and 2 above.

.....
FULL NAME

.....
DATE

SIGNATURE

CONDITIONS PERTAINING TO EN-SUITE ROOMS

1. Should at any time during my stay in an en-suite room I become physically incapacitated to the extent that the Home is unable to provide the level of care that I require in an en-suite room, I will be required to vacate the room and move to a section in the Home where the correct care be given to me.
2. Should at any time during my stay in an en-suite room I become mentally frail to the extent that I am unable to function at the level as set out in the criteria as defined by Highlands House, I understand that I will have to vacate my room.
3. Should at any time during my stay in an en-suit room I find myself unable to pay the fee, I understand that there will be no deferment of any part of the fee and I will be required to vacate the room.
4. The provision of extra nursing care (a special) will in no way be accepted as an alternative to moving as the move is being made because I no longer fit the criteria of my en-suite room.
5. Should my move be to a room with lesser facilities, I understand that an adjustment to the fee payable will be made.
6. Should I have to vacate my room and move to a section of the Home where the correct care can be given to me, I understand that I will have to pay for all costs involved in a room transfer. eg. Telephone transfer, television installation. I accept that these costs will be for my account.

I understand that should it be necessary for me to vacate my room for reasons as mentioned in paragraph 1 and 2 above, Highlands House will endeavour to find me accommodation similar to that of the room I will be vacating. I do however understand and accept that this might not be possible at the time of the need for me to vacate the en-suite room and I will be placed in an available room. The Home undertakes to supply me, as soon as is practically possible, with accommodation comparable to that which I have vacated.

I accept that Highlands House's inter-disciplinary team together with the Home's Medical Sub-Committee, will be the final arbiters in regard to the necessity for me to move should the need arise.

I understand clearly and accept that Highlands House will not have to pursue any formal procedure to enforce its rights as mentioned in paragraphs 1,2 and 3 above.

.....
FULL NAME

.....
DATE

SIGNATURE.....

1. I certify that before administering the oath/affirmation, I asked the deponent the following questions and wrote down his/her answers in his/her presence.

a. Do you know and understand the contents of the declaration?

Answer

b. Do you have you objection to taking the prescribed oath?

Answer

c. Do you consider the prescribed oath to be binding on your conscience?

Answer

2. I certify that the deponent has acknowledged that he/she knows and understands the contents of this declaration which was sworn to/affirmed before me and the deponent's signature/thumb print/mark was placed thereon in my presence.

.....
COMMISSIONER OF OATHS

.....
DATE

I,....., Next of kin of

Do hereby understand and accept the above undertaking that my

Is signing.

.....
FULL NAME

.....
DATE

SIGNATURE

DEPARTMENT OF SOCIAL SERVICES
Statement of Income and Expenditure by
Residents of Homes for the Aged and Homes for the Disabled

Name:.....

ID No.....

A. INCOME 1. PENSION RECEIVED (type of pension)	REFERENCE NO Where applicable	MONTHLY INCOME E.g. interest, dividends, rent etc.	
		SELF	SPOUSE
1.1			
1.2			
1.3			
1.4			
2. ANNUITY (Name of Fund)			
2.1			
2.2			
2.3			
2.4			
3. INCOME FROM TRUST FUND AND MAINTENANCE ALLOWANCES (Name of fund/person)			
3.1			
3.2			
3.3			
3.4			
4. SHARES			
4.1			
4.2			
4.3			
5. DIRECTOR'S FEES (Name of Company)			
5.1			
5.2			

6. CASH INVESTMENTS (Specify financial institution)		AMOUNT	MONTHLY INCOME E.g. interest, dividends, rent etc.	
			SELF	SPOUSE
6.1				
6.2				
6.3				
7. FIXED PROPERTY e.g. Farms, dwellings etc. (Full description and where situated)			MONTHLY INCOME E.g. interest, dividends, rent etc.	
			SELF	SPOUSE
	PRESENT VALUE	BOND IN ARREARS		
7.1				
7.2				
7.3				
8. OTHER SOURCES OF INCOME (specify e.g. Income from business, usufruct/Fidei Commissum)				
8.1				
8.2				
8.3				
GRAND TOTAL				

B. TOTAL VALUE OF ASSETS SOLD AND DONATIONS MADE OVER THE LAST 5 YEARS (specify)		MONTHLY INCOME E.g. interest, dividends, rent etc.	
1. ASSETS SOLD		SELF	SPOUSE
1.1	Date Sold		
1.2	Amount Received		
1.3	Amount for which transfer duties were paid		
2. ASSETS DONATED			
2.1	Date		
2.2	Value		
3. CASH DONATED			
3.1	Date		
3.2	Value		

C. EXPENDITURE OF CONTINUOUS NATURE (Documentary proof of expenditure must be furnished) Specify e.g. medical fund, subscription fees, fees, tax, bond installments etc.			
1.1			
1.2			
1.3			
TOTAL			

I herewith declare that the information furnished by me is, to the best of my knowledge,
true and correct.

.....
SIGNATURE OF APPLICANT/AUTHORIZED PERSON

.....
DATE

1. I certify that before administering the oath/affirmation, I asked the deponent the following questions and wrote down his/her answers in his/her presence.

- Do you know and understand the content of the declaration? Answer:

Y	N
---	---
- Do you have any objection in taking the prescribed oath? Answer:

Y	N
---	---
- Do you consider the prescribed oath to be binding on your conscience? Answer:

Y	N
---	---

2. I certify that the deponent has acknowledged that he/she knows and understands the content of this declaration which was sworn to/affirmed before me and the deponent's signature/thumb print/mark was placed thereon in my presence.

.....
COMMISSIONER OF OATHS FOR
THE REPUBLIC OF SOUTH AFRICA

.....
DATE

.....
PLACE

**FOR OFFICIAL USE BY A SCREENING OFFICER OF
THE DEPARTMENT OF HEALTH SERVICES & WELFARE**

GROSS INCOME

R.....,

MINUS APPROVED EXPENDITURE (Specify)

NETT INCOME*

*The latter amount must be entered on the screening certificate

R.....,

INCOME GROUP CODE

.....
OFFICER EMPLOYED BY THE DEPARTMENT
OF HEALTH SERVICES & WELFARE

.....
DATE