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t: 051 436 6034
f: 086 457 3627
e: admin@fsnasorg.org
w: www.fsnasorg.org

vs nasorgsentrum
residential care centre

Application Form 2023

Name of Applicant: ____________________
Date: ____________________

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Criteria for admittance

***Please note:** All new applicants will be admitted for a probation period of three (3) months. The applicant will need to adhere to evaluations and additional tests that are required by the Centre*

1. Person must be diagnosed with Intellectual Disability
2. Person must have an IQ of 30-70
3. Person must be between the age of 18 and 40
4. Person above 40 will only be admitted if transferred from a similar institution or if found acceptable by the selecting Committee
5. Person must be independent regarding self-care e.g., bathing and dressing
6. Person must be able to comprehend instructions in Afrikaans, English or Sesotho and be understandable by others
7. The application of a person with a brain injury will be thoroughly examined and the final selection depends on the selection committee
8. The person must already receive a SASSA Grant
9. An additional monthly fee will be expected from the parent/guardian. The amount will be determined by the Board of Management and is subjected to change from time to time
10. Intakes occur twice a year, in January and in June

Accompanying forms

Please note: Failure to include all the required documentation with your application form will render it incomplete and ineligible for consideration.
To indicate the attachment of forms, please place a checkmark next to each required document

1. Fully completed and signed document ☐
2. Section C: Report card from school/institution ☐
3. Section E: Road to Health booklet ☐
4. Section F: Medical report completed by **general practitioner** ☐
5. Section G: Medical report completed by **psychiatrist** ☐
6. Section H: Social report completed by **social worker** ☐
7. Section I: Medical aid card (if applicable) ☐
8. Section I: ID documents of caregivers ☐
9. Section J: Salary advises and bank statements ☐

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Concept clarification:

Free State Residential Care Centre offer the following services:

Residential care facility:
A facility that provides 24-hour care, meals, and support to its residents

Sheltered workshops:
Sheltered workshops are organisations which specifically employ disabled people by creating employment opportunities that would not exist without the intervention. These workshops cater for the population of people who would not otherwise have access to the open labour market.

We kindly ask that you fill in this application form truthfully and completely. This information is essential in helping us make the right choice for the applicant.
Failing to provide accurate and complete information may result in our inability to make an informed decision regarding your application.

Therefore, we cannot be held responsible for any adverse outcomes that may arise from incomplete or false information provided on the form. We appreciate your cooperation and thank you for considering our application process.

For any questions regarding application please contact the Occupational Therapist, Mrs. Lizelle Coetzer at 051 436 6034 or ot@fsnasorg.org.

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Adapted fee structure July 2023

The fee structure is set out as follows:

Residents		
	Fee composition	**Description**
Subsidy room	SASSA grant - R2 080, 00 Parent/Guardian contribution - R1 272, 00	Sharing room with at least 3 other residents
Standard sharing room	SASSA grant - R2 080, 00 Parent/Guardian contribution - R2 873, 00	Sharing room with 2 other residents
Single room	SASSA grant - R2 080, 00 Parent/Guardian contribution - R4 780, 00	The resident will have a room to themselves

SASSA grants need to be paid in full to the Centre. It is the responsibility of the family/guardians of a resident to arrange with the Department of Social Development that this payment is made directly into the Centre's account. This amount forms an integral part of the Resident fee and must be paid in full to the Centre

Dayworkers	
Fee composition	**Description**
R2 120, 00	Bus service Lunch
R1 484, 00	Own transport Own meals Or special arrangement e.g., only attends few days a week

Physical Address
Bloemendal Road, Rayton, Bloemfontein, 9301

Postal Address
PO Box 128, Bloemfontein, 9300

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Section A: Application for admittance:

Type of service required (*mark where applicable*):

Dayworker	Resident

- Name: ____
- Identity number: ____
- Date of birth: ____
- Gender (*mark where applicable):*

Male	Female

- Marital status (*mark where applicable):*

Single	Married	Divorced

- Children (*mark where applicable):*

Yes	No

If yes, please provide the following details:		
Name/s	**Age/s**	**Primary caregiver**

- **Disability grant:**

Yes	No

- Religious denomination: ____

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- Home language: ____
- IQ (if known): ____

Section B: Details of Primary Caregiver

- Name and Surname: ____
- Residential Address: ____
  ____
  ____
  ____
- Postal Address: ____
  ____
  ____
  ____
- Contact details:
  Telephone
  Home: ____
  Work: ____
  Cellular: ____
  Email address: ____

Family information (*mark where applicable*):

Biological mother		Biological father		Adoptive Parent	
Stepmother		Stepfather		Other	

- **Additional information**

	Mother	Father
Age:		
If deceased, cause of death:		
Health Status:		
Profession:		
Highest qualification		
Home language:		

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Close relatives:

Brothers & sisters and other close relatives			
Relationship:	Name:	Age:	Contact details:

Health history of immediate family (*mark where applicable*):

High blood pressure		Diabetes		Gout	
Cholesterol		Insulin resistant		Arthritis	
Epilepsy (specify)		Cancer (specify)		Other (specify)	

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Section C: Previous school/institution

Provide an attached copy of the report card issued by the applicable school or institution

- Name: ____
- Duration of attendance: ____
- Contact person of school/institution: ____
- Telephone number: ____
- Email address: ____
- Scholastic abilities:

Reading (mark where applicable):

Only name	Words	Sentences

Writing (mark where applicable):

Only name	Words	Sentences

Following of instructions (mark where applicable):

Only visual instructions	1-3 steps verbal instructions	Multiple steps verbal instructions

- Subjects/workshops completed: ____
____
____
____
____
- Highest grade/level completed: ____

Behaviour:

- Any behavioural challenges: __________________________________
____
____
____
____

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- How does the applicant react to discipline: ___________________________________
____
____
____
____

- What type of discipline methods is used: ___________________________________
____
____
____

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Section D: Independence

We emphasize the importance of answering truthfully, as it will enable us to assess the needs accurately and provide the applicant with the correct care, assistance, or supervision. If the applicant requires a lot of motivation to complete a task, please indicate this in your response.

Physical/psychological ability	For office use	Mark with "X" where applicable	Elaborate if needed
1. Mobility			
Moves around without assistance	0		
Needs supervision/assistance with mobility (including wheelchairs/walking aids)	2		
Totally dependent on assistance for mobility	4		
2. Dressing			
Dresses self and can appropriately select clothing	0		
Needs supervision/assistance with dressing and choosing clothing	2		
Completely dependent	4		
3. Bathing/washing			
Showers/baths independently	0		
Must be encouraged or needs supervision/assistance	2		
Completely dependent	4		
4. Shaving			
Completely independent	0		
Needs supervision/assistance	2		
Completely dependent	4		
5. Hair care			
Completely independent	0		
Needs supervision/assistance	2		
Completely dependent	4		
6. Oral/dental care			
Independently brush teeth without prompting	0		
Needs assistance/supervision or prompting	2		

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Completely dependent	4		
7. Incontinence			
None	0		
Partly incontinent	2		
Completely incontinent of urine and bowels (uses incontinence products)	4		
8. Taking of medication			
Able to take own medication	0		
Needs supervision/assistance when taking medication	2		
Totally dependent on others for taking medication	4		
9. Eating			
Enjoys meals and can eat unaided	0		
Needs supervision/assistance with feeding and mealtimes	2		
Completely dependent on assistance during mealtimes	4		
10. Environmental tidiness			
Makes bed self and cleans own environment without needing prompting	0		
Needs supervision/assistance or prompting	2		
Completely dependent	4		
11. Use of telephone			
Independently uses a telephone	0		
Needs supervision/assistance	2		
Completely dependent	4		
12. Sociability			
Gets on well with others and in groups	0		
Often needs alone time or time-out from others	2		
Unable to adapt to others and in group settings	4		
13. Communication ability			
Able to communicate	0		
Communicates with difficulty	2		
Unable to convey needs	4		
14. Handling of money			
Independently identifies and spends money	0		

Needs supervision/assistance	2		
Completely dependent	4		
15. Preparation of food			
Independently prepares simple foods	0		
Needs supervision/assistance	2		
Completely dependent	4		
16. Preparation of beverages			
Independently prepares beverages (including using a kettle)	0		
Needs supervision/assistance	2		
Completely dependent	4		
17. Sense of danger			
Able to identify and correctly react in dangerous situations (fire etc.)	0		
Needs supervision/assistance	2		
Completely dependent	4		
18. Swimming ability			
Swim independently and safely	0		
Needs supervision/assistance	2		
Unable to swim	4		
19. Ability of routine work			
Independently participate in routine work	0		
Needs prompting, supervision, or assistance to complete tasks	2		
Unable to independently do routine work	4		
20. Tendency of theft			
No	0		
Sometimes	2		
Yes	4		
Total:	**/72**		**For office use only**
General comments:			

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- Interest/hobbies of applicant:

____
____
____
____

- Can the applicant independently initiate their participation in these areas of interest:

____
____
____
____
____

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Section E: Medical information

The parent/legal guardian is responsible for completing this section of the document

- Childhood diseases and immunizations

Please attach a copy of the Road to Health Booklet

	Yes	**No**
Immunizations:		
Diphtheria		
Tetanus		
Measles		
Polio		
Diseases:		
Measles		
German Measles		
Mumps		
Chicken Pox		
Whooping Cough		
Epilepsy		
Porphyria		

- Pregnancy/birth history of biological mother (mark where applicable):

Normal pregnancy and delivery		Mother experienced abuse/trauma during pregnancy		Low oxygen levels during birth	
Drug/alcohol use during pregnancy		Premature birth		Brain injury/trauma after birth	

- Birth control of applicant (mark where applicable):

Yes	No

If yes, mark where applicable:

	Oral contraceptives
	Name of medication:
	Operation
	Hysterectomy
	Sterilization
	Injection
	Depo-Provera
	Nur-Isterade

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- Current medical condition (e.g., allergies, epilepsy, diabetes etc.)

____
____
____
____

- Medication (e.g., Epilim 300mg bd)

Name	**Dosage**	**Frequency** ***(e.g., morning, afternoon, evening)***

- Physical conditions (e.g., weakness on one side of the body etc.):

____
____
____

- General health (e.g., frequency of getting the flu or other illnesses)

____
____
____

- Does the applicant wear glasses/contact lenses:

Yes	No

If yes, please provide the following:

Name of provider (e.g., Specsavers etc.)	
Date of last appointment	

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- Does the applicant wear hearing aids:

Yes	No

If yes, please provide the following:

Name of provider (e.g., Ear Institute)	
Date of last appointment	

- Name, telephone number and address of family doctor

____
____
____

- Is the applicant seeing any specialist doctor (e.g., neurologist, urologist etc.)

Yes	No

If yes, please provide the following:

Name and Surname of Doctor	
Date of last appointment	
Date of follow up appointment	

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Section F: Medical report

This section is to be completed by a qualified general practitioner capable of providing a comprehensive and precise report on the applicant's medical history and current health status

With this report, please also include:

- ***Blood tests (Full blood count, Epilim levels (if applicable) and/or HbA1C (if applicable)***
- ***Any medical reports dating back 5 years***
- ***Current medication prescription***

- Name of applicant being examined: ______________________________
- Date of examination: ______________________________
- Number of years you have been treating applicant: ______________________________

- General health:

Heart rate:	Blood pressure:	BMI:	Blood sugar level:

Is the applicant currently suffering from any of the following?	Yes	No	Elaborate if necessary
Respiratory system conditions e.g., asthma			
Cardiovascular and haematological conditions e.g., hypertension, anaemia etc			
Genito-urinary tract conditions e.g., incontinent, prone to infection			
Digestive system and other abdominal systems conditions e.g., diabetes mellitus, constipations, ulcers etc.			
Muscular and skeletal system conditions or defects e.g., scoliosis, osteoporosis, arthritis			

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Skin/hair conditions e.g., psoriasis, eczema			
Hearing and eyesight condition			
Any other condition not mentioned in the classification above			
General comments:			

- Epilepsy (if applicable):

Type of epileptic attack: ____
Frequency of attacks: ____
Name and contact details of applicant's neurologist: ___________________________________
Last date seen: ____
Date of next appointment: ____

- Diabetes (if applicable):

Type of diabetes: ____
How long has the applicant had diabetes: ____
Is the diabetes controlled: ____
Any other experienced complications: ____
____

- Allergies (if applicable):

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Specify: ____

- Physical disabilities (if applicable):

Specify: ____
____

Physical aids used: ____

- Medication (include all medication the applicant is currently using):

Medication	Dosage	Frequency

- Medical practitioner information:

Name and Surname: ____
HPCSA Reg nr/Practice nr: ____
Address: ____
____
____
Telephone number: ____
Email address: ____
Signature:

……………………………………………………

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Section G: Psychological report

This section is to be completed by a registered psychiatrist capable of providing a comprehensive and precise report on the applicant's psychological history and current mental health condition/s

With this report, please also include:

- ***Any medical reports dating back 5 years***
- ***Current medication prescription***

- Name of applicant being examined: ______________________________
- Date of examination: _____________________________
- Number of years you have been treating applicant: ______________________________
- Intellectual Disability

Degree of intellectual disability: ____
Cause of intellectual disability: ____

- Mental Status Examination

Appearance and behaviour:

____
____
____

Speech and thought processes:

____
____
____

Mood and affect:

____
____
____

Perception and cognition:

____
____
____

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Insight and judgment:
____
____
____

- Diagnostic impression

Description of the applicant's mental health diagnosis, if applicable:
____
____
____

Relevant diagnostic criteria:
____
____
____

- Treatment history

Past and current treatment modalities:
____
____
____

Response to treatment:
____
____
____

Medication (Please provide a comprehensive list of all medications applicable to the applicant's psychological condition/s):

Medication	Dosage	Frequency

- Medical practitioner information:

Name and Surname: ____
HPCSA Reg nr/Practice nr: ____
Address: ____
____
____
Telephone number: ____

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Email address: ____

Signature:

……………………………………………………….

….

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Section H: Social report

This part is to be completed by a registered social worker

- Name of applicant being examined: ______________________________
- Date of examination: _____________________________
- Support system (family composition of applicant; siblings, emotional and financial support available):

____
____
____
____
____
____
____
____

- Housing and transport

During holidays, will the applicant return home, or is there any alternate accommodation? Please indicate contact person's name, address, and telephone number.

____
____
____
____
____
____

- Behaviour

Is the applicant's behaviour socially acceptable? Any history of behavioural issues?

____
____
____
____
____

Is the applicant adjustable to new circumstances?

____
____
____

How is the applicant's ability to share with other people?

____
____
____

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- Social worker information:

Name and Surname: ____
Address: ____
____
____
Telephone number: ____
Email address: ____
Signature:

……………………………………………………

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Section I: Financial Responsibility

- **Medical Aid:**

Does the applicant have a medical aid:

Yes	No

If yes, please provide the following:

Attach a copy of the medical aid card	
Name of medical aid:	
Main member:	
Membership number	
Applicant beneficiary number:	

- **Trust:**

Will account payments be made by a trust:

Yes	No

If yes, please provide the following:

Name of the trust:	
Contact person:	
Telephone number	
Email	
Monthly contribution to applicant:	
- Boarding	
- Personal expenses	
- Other	
TOTAL:	

- **Primary Person responsible for settlement of the account:**
  Please attach of copy of Identity Document

Full name and Surname	
Date of birth	
ID number	
Cell number	
Email	
Employer	

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Home address	
Postal address (if different from home address)	

- **Secondary Person responsible for settlement of the account:**
  Please attach a copy of Identity Document

Full Name and Surname	
Date of birth	
ID number	
Cell number	
Email	
Employer	
Home address	
Postal address (if different from home address)	

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Section J: Declaration of income and expenditure

Please attach a copy of salary advice and 3-month bank statements

- Name of primary person responsible for account: ______________________________________
- Name of applicant: ______________________________________

Income			**Expenses**	
Source of income	**Primary Person Responsible**	**Secondary Person Responsible**	**Source of expense**	
Salary	R	R	Home Loan/Rent	R
Pension **SASSA pension is not included in this section*	R	R	Living Expenses (Groceries, clothing etc.)	R
Rental	R	R	Water & Lights/Levy/Property tax	R
Other Income *(specify)*			Vehicle/Motor Finances	R
	R		Transport (Petrol/Maintenance)	R
	R		Telephone/DSTV/Cell	R
	R		Insurance (Car/Household)	R
Total income per person	R	R	Education/School	R
Total Combined Income	**R**		Medical Fund	R
Deductions (Tax etc.)			Other medical expenses (e.g., prescription medication)	R
Total NET Income	**R**		Pocket money (to applicant/other children)	R
			Credit Card Payments	R
			Other expenses	R
				R
			Total Expenditure	**R**

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For office use only	
Disposable income/Net Surplus (income – expenses)	**R**

Declaration:

I ________________________________ hereby declare that all the information provided in this application form is true, accurate, and filled out to the best of my knowledge. I understand that any misrepresentation or omission of facts may result in the rejection of my application or termination of my enrolment at the Centre.
I affirm that I have disclosed all relevant details regarding my income, expenses, and any other required information. I acknowledge that it is my responsibility to update the Centre promptly if there are any changes to the provided information.
I understand that the Centre reserves the right to verify the accuracy of the information provided in this application, and I consent to any necessary verification processes, including contacting relevant authorities or third parties.
I further understand that providing false or misleading information may have legal consequences and may affect the eligibility of the applicant for enrolment at the Centre.
By signing below, I affirm my understanding and acceptance of the above declaration.

Signature: ………………………………………………

Date: ____________________

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Section K: POPI Disclaimer with respect of beneficiary information

All parties agree that they will comply with the POPI regulations and process all the information and/or personal data in respect of the services being rendered in accordance with the said regulation and only for the purpose the Services set out in agreement to provide services.
It is confirmed that by submitting information to Vrystaat Nasorgsentrum (Free State Residential Care Centre), irrespective as to how such information is submitted, you consent to the collection, collation, processing, and storing of such information and the use and disclosure of such information in accordance with the policy.
Vrystaat Nasorgsentrum (Free State Residential Care Centre) (also called the service provider), all the parties to this agreement, the service provider's employees and the client's employees and any subsequent party/parties to this agreement acknowledge and confirm that.

- One or more of the parties to this agreement, will possess and will continue to possess information that may be classified or maybe deemed as private, confidential, or as personal information
- Such information may also be deemed as or considered private, confidential, or as personal information of any third person who may be directly or indirectly associated with this agreement
- Further, it is acknowledged and agreed by all parties to this agreement, that such private, confidential, or as personal information may have value and such information may or may not be in the public domain.

Further it is specifically agreed that the Vrystaat Nasorgsentrum will use its best endeavours and take all reasonable precautions to ensure that any information provided, is only used for the purposes it has been provided

By signing below, I confirm my understanding and acceptance of the POPI disclaimer and grant consent for the Centre to process personal information as outlined.

Signature:

…………………………………….