

**HELPE NDE HANDE FRAIL CARE CENTRE**

Ward 19 | Stikland Hospital Grounds | De la Haye Rd | Bellville | 7530

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## APPLICATION FOR ADMISSION

Helpende Hande Frail Care Centre is a private institution. We have no relation with Stikland Hospital. We share only the grounds of the Hospital

**ADMISSION REQUIREMENTS**

1. Family members must sign all forms.
2. A doctor must complete the medical report in order for the patient to be admitted.

Only frail care patients are allowed in the centre. It is therefore very important that all the following application forms are completed correctly.

- Application form
- Medical report from doctor
- Details of family members

**ADMISSION FEE**
**R**
**\*\* is payable with admission and not refundable.**
**ADDITIONAL DOCUMENTATION**
**PLEASE ATTACH THE FOLLOWING TO YOUR APPLICATION**

1. Copy of patients ID
2. Copy of medical aid card (if any). &
3. Copy of Family/friend ID &
4. Copy of Person responsible for the payment of fees ID.

**Patient Information**

Surname

Full Names

Date of Birth

ID Nr.

Gender

Marital Status

Religion

Place of Birth

Funeral Service

Tel



## Helpende Hande Rules and Regulations

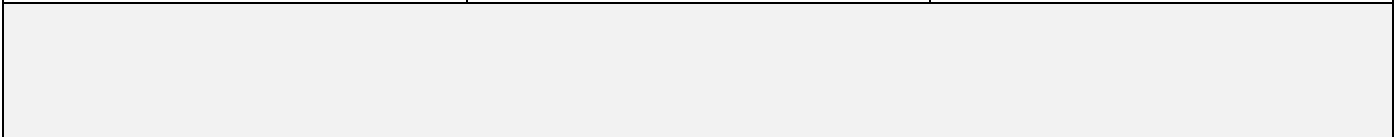
<p><b>Visiting hours:</b></p> <p>15:00 – 16:00 19:00 – 20:00</p> <p>Please sign our visitor book and write comments.</p>	<p><b><u>1. Excursions</u></b></p> <ul style="list-style-type: none"> <li>• Please notify the centre if you will be taking out a patient for the day</li> <li>• Please complete the register if you take any patient away from the centre</li> </ul> <p><b><u>2. Medication</u></b></p> <ul style="list-style-type: none"> <li>• All prescribed medication with a copy of the ordinance to be accompanied.</li> <li>• No medication will be administered without a prescription.</li> <li>• No medication may be given to patients by family members, or to be kept in rooms.</li> </ul> <p><b><u>3. General</u></b></p> <ul style="list-style-type: none"> <li>• No drinking or smoking will be allowed on the premises.</li> <li>• No intoxicated visitors will be allowed.</li> <li>• Children must be accompanied by parents and they may not be a nuisance to other patients.</li> </ul> <p><b><u>4. Requests &amp; Complaints</u></b></p> <ul style="list-style-type: none"> <li>• Any request or complain must be in writing and addressed to the manager,</li> <li>• No complaints to be discussed with patients.</li> </ul>
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<b>Rules &amp; Regulation Declaration</b>	I, ..... undertake to adhere to the 'Rules and Regulations' of Helpende Hande Frail Care Centre.	
	SIGNATURE (Family/Friend)	
	SIGNATURE (Manager)	
	DATE	

### Indemnity

I, ..... family / friend of .....  
(patients name) Indemnify the staff and management of Helpende Hande Frail Care Centre against any claims which may arise from any injury or damage to above mentioned patient or property howsoever caused. I also grant permission for the administration of emergency medical treatment that may be considered necessary for the above mentioned patient in my absence and accept full responsibility for the account.

SIGNATURE (Family/Friend)	SIGNATURE (Manager)	DATE



## Financials

<b>Rates</b>	General Ward	<b>R</b>	Private Room	<b>R</b>	Admission Fee	<b>R</b>
<p><b>Monthly fees include:</b></p> <ul style="list-style-type: none"> <li>• Accommodation and three meals (breakfast, lunch, supper)</li> <li>• 24 hours care.</li> </ul> <p><b>Monthly fees exclude:</b></p> <ul style="list-style-type: none"> <li>• All prescribed tube feeding</li> <li>• Wound care material</li> <li>• Insertion of catheters / feeding tubes.</li> <li>• Washing</li> <li>• Nappies **</li> </ul> <p><b>** Families are responsible for the nappies of patients. It is very important that patients have the correct amount and size of nappies at all times.</b></p> <p><b>Payments:</b></p> <ul style="list-style-type: none"> <li>• All payments are strictly payable in advance, preferably by debit order.</li> <li>• Annual increase of 12% after every 12 months from the date of admission.</li> <li>• A 10% levy will be charged for late payment.</li> <li>• All cost incurred for late payments will in fact be added. eg. Telephone calls, faxes.</li> <li>• One month (30 days) notice must be given in writing.</li> <li>• No fees will be refunded on cancelation of contract or by death of patient.</li> </ul>						

### Agreement of payment

Patient's Name				Person responsible for the payment of fees	
Monthly Fee	<b>R</b>	Admin Fee	<b>R</b>	Person responsible ID No.	
<b>Debit order details:</b>	<b>Helpende Hande</b> ABSA Bank Brackenfell Branch Acc. nr: 9141280835 Savings account		<b>Reference Indicator on Payment entries</b> Ref: Accommodation for: [...Patient's Name...]		<b>NOTE</b> <b>No Refund of Admission Fee or on Cancellation of Agreement</b>

I, ..... understand and accept that the payment of fees is compulsory and that it is due before the ..... of every month via debit / stop order. I accept that should I neglect to pay, I would be handed over to the attorneys. I will also be held responsible for whatever costs may be added to my account. If a cash payment is made for fees, I accept that a penalty of R50.00 will be charged additionally for bank charges attached to cash deposit. One month's written notice must be given in the event of a patient leaving the centre or ending the contract

SIGNATURE (Person responsible for the payment of fees)	SIGNATURE (Manager)	DATE