



**EverGrace Care**

## APPLICATION FORM

PLEASE TICK ACCOMMODATION TYPE AND NUMBER OF PERSONS APPLYING FOR:

- INDEPENDENT UNITS/ASSISTED LIVING – APARTMENTS GROUND FLOOR
- FRAIL CARE – SINGLE ROOMS WITH SHARED BATHROOM
- ASSISTED LIVING – SHARED DOUBLE BEDROOM WITH PRIVATE BATHROOM
- ASSISTED LIVING – SINGLE OCCUPANCY DOUBLE BEDROOM

Number of persons applying for: \_\_\_\_\_

Date of occupation: \_\_\_\_\_

READ THE APPLICATION CAREFULLY, SHOULD ANY EXPLANATIONS BE REQUIRED KINDLY CONTACT OUR OFFICE.

1. All details must be provided.
2. Spouses are required to complete their own application forms.
3. An undertaking of Next-of-kin to be completed and signed by the family member concerned.
4. Medical forms (as attached) to be completed by your Medical Practitioner in as much detail as possible and must accompany your application.
5. Other Forms to be attached to application: ID of applicant and person responsible for account, Medical Script and Copy of Medical Aid Card.

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 [Management@evergracecare.com](mailto:Management@evergracecare.com)

 13 Wilson Street / 4 Shackleton Street,  
Gonubie, 5257



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## APPLICANT DETAILS:

Full name and surname: \_\_\_\_\_

Phone number: \_\_\_\_\_

Present address: \_\_\_\_\_

\_\_\_\_\_

Date of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_

Identity number: \_\_\_\_\_

Nationality: \_\_\_\_\_

Home language: \_\_\_\_\_

Religious denomination / congregation: \_\_\_\_\_

Congregation minister/pastor: \_\_\_\_\_

Congregation minister/pastor telephone: \_\_\_\_\_

General interest / activities: \_\_\_\_\_

Do you require a car port? (these are available on a first come first serve basis) YES / NO

Are you a smoker? YES / NO

Do you consume alcohol? YES / NO

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Auxillary care needed: (please tick)

- Physiotherapy
- Occupational therapy
- Dietician
- Psychologist
- Social worker
- Wound care nurse
- Other: \_\_\_\_\_

Medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Dietary requirements: \_\_\_\_\_

**Please attach all medical scripts to application form.**

## **MEDICAL AID DETAILS:**

Medical aid: \_\_\_\_\_

Medical aid plan: \_\_\_\_\_

Membership no: \_\_\_\_\_

**Please attach copy of medical aid card to application.**

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## CURRENT/PREVIOUS FACILITY DETAILS:

Current facility: \_\_\_\_\_

Referring provider: \_\_\_\_\_

Treating doctor's name: \_\_\_\_\_

Treatment details: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

Current facility phone number: \_\_\_\_\_

Previous facilities, and reasons for transfer: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## GENERAL PRACTITIONER'S DETAILS:

Do you have your own General Practitioner? YES / NO

If Yes please complete below:

Name and surname: \_\_\_\_\_

Address of practice: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Would you like to make use of our in-house referring General Practitioner? Additional GP Fees will still be charged. YES / NO

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## EMERGENCY CONTACT DETAILS:

In the event of an emergency / change in medical condition / death, please provide us with name of two contactable persons. Please state relationship.

1. Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone/cell: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone/cell: \_\_\_\_\_

## NEXT-OF-KIN

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone/cell: \_\_\_\_\_

## LEGAL ADVISOR

Name of your legal advisor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Power of attorney: \_\_\_\_\_

(It is a condition of admission that, in the event of you not being able to conduct your financial or medical affairs, your Power of Attorney be held by either your financial institution, lawyer, or next-of-kin)



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Do you have a Funeral Policy? YES /NO

If yes, please provide undertakers details:

Firm of Undertakers: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone: \_\_\_\_\_

In the event of your death and not having a funeral policy, please state name and address of person responsible for any debts incurred:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

Phone / Cell: \_\_\_\_\_

Signature of person responsible for any debts incurred: \_\_\_\_\_

Date: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT:

Name and surname: \_\_\_\_\_

Address: \_\_\_\_\_



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Please provide two contact numbers and an email address; all account related information will be communicated via the provided number(s) and email address.

**Please attach a copy of the ID of the person responsible for account.**

Phone / Cell: \_\_\_\_\_

Phone / Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

Signature: \_\_\_\_\_

## **BANK DETAILS:**

Account holder: \_\_\_\_\_

Account number: \_\_\_\_\_

Bank: \_\_\_\_\_

Branch name: \_\_\_\_\_

Branch code: \_\_\_\_\_

I submit the application to the above Frail Care / Assisted Living Institute, once admitted; undertake to comply with the Rules and Regulations in operation for the time being, and such alterations as may be made to such rules from time to time. I acknowledge receipt of a copy of the Rules and Regulations in operation as at the date of signing this agreement.

I declare that the information given in this agreement has been accurately and fully stated.



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My monthly accommodation fees will be settled in advance, before the 7th day of each calendar month, and I agree to any variation/addition of charges necessitated; for transport, phone calls made, auxiliary medical referrals medical supplies, or special personal requests.

I also note and agree that:

EverGrace Care cannot accept any responsibility for any personal possessions, jewellery, documents, appliances etc. brought into / onto the premises by either the resident or person visiting the premises, or for any injury sustained by a resident. Should the necessity arise for an urgent emergency operation on me, and my next-of-kin is not available, THE NURSING SISTER shall furnish the consent required by the hospital.


DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Relationship to applicant if signing on their behalf: \_\_\_\_\_

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