ALGOA BAY COUNCIL FOR THE AGED

Buffelsfontein Village, Cuylerholme Rooms, Almaza, Alamein

Application For Double Accommodation

ADMISSION CRITERIA

Minimum age for application is **sixty (60).** Applications for **younger persons** will be registered only and will **not be placed on the waiting list** until the minimum age is attained.

Applicant must preferably be a resident in the Nelson Mandela Metro i.e. Port Elizabeth, Despatch, Uitenhage or the immediate surrounding areas.

Applications from persons already in a retirement home **will not be considered for accommodation** in one of our facilities.

Applicants need to complete the necessary application form. The medical form must be completed by a Doctor, clinic sister or practising medical sister.

All our facilities are intended for fit persons - **ABCA DOES NOT PROVIDE FRAIL OR NURSING CARE.**

It is compulsory for applicants to have a funeral policy and proof of such policy must be provided.

Applicants who are allocated a unit may be required to have a family member or acquaintance sign a surety agreement with Algoa Bay Council For The Aged.

THE FOLLOWING DOCUMENTS MUST ACCOMPANY THE APPLICATION FORM:

- Copy of identity document
- Three (3) months' bank statements
- Copy of any other proof of income
- Proof of a funeral policy

Process to return this form: Hand in at Head Office, post, email or fax.

You will receive an acknowledgment of receipt (via post), which will indicate the reference number allocated to your application.

A screening interview must be arranged with our Social Worker where after, if suitable, you will be placed on the waiting list for accommodation.

As we have an extended waiting list we generally **cannot assist with emergency accommodation.** We request applicants to be patient once on the waiting list. **You will be contacted when accommodation is available.**

Previous residents **will not be given preference** should they re-apply for residence.

Date of application does not influence the applicants place on the waiting list. Admissions are determined by a team and not by an individual.

Forms **MUST BE COMPLETED IN FULL** and signed by a Commissioner of Oaths and contain all requested documentation. Forward your application to (faxed copies are not accepted):

Algoa Bay Council For The Aged
PO Box 15333
Emerald Hill
Port Elizabeth
6011

February 2017

Detach this page for your information

ALGOA BAY COUNCIL FOR THE AGED

Application For Double Accommodation

FOR OFFICE USE

Reference No: _____ Date Received: _____

Facility: _____

Points Allocated: ☐

Acknowledgment 1: _____ Initial: _____

Income Code: _____

Acknowledgment 2: _____ Initial: _____

Interview Date: _____ Initial: _____

Age: _____

Rental Code: _____ Reason: _____

Comments:

_____

_____

_____

Suitable: _____ Unit Allocated: _____ Effective Date: _____

Facility Application For

BUFFELSFONTEIN VILLAGE ☐ CUYLERHOLME ROOMS ☐ ALMAZA ☐ ALAMEIN COURT ☐

Personal Information (Partner 1)

Identity Number ☐☐☐☐☐☐☐☐☐☐☐☐☐ *Please attach a copy of your ID*

Title ☐☐☐☐ **Surname:** _____

First Names: _____

Male ☐

Female ☐

Population Group
(As on population register. *For statistical reasons only*):

Asian ☐ **Black** ☐ **Coloured** ☐ **White** ☐

Marital Status: **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Single (Never Married)** ☐

Home Language: **English** ☐ **Afrikaans** ☐ **Xhosa** ☐ **Other:** _____

Telephone No (Home) ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

Other (Please specify) ☐☐☐☐☐☐☐☐☐☐ _____

Email Address: _____

Current Accommodation

Residential Address: _____

_____

_____

_____

Postal Address: _____

_____

_____

_____

Postal Code: _____

Postal Code: _____

For How Many Years: _____

Is Your Current Accommodation: **Rented** ☐ **Owned** ☐

If rented please supply the following information: **Monthly Rental:** _____

Landlord/Agent: _____ **Telephone No** ☐☐☐☐☐☐☐☐☐☐

Financial Details

Proof of Income and three (3) months' bank statements to be attached:

Income (Other includes family assistance, salary etc):

Type Of Pension	Reference No	Amount Received	Total Monthly Income
		R	
		R	
Other Income	**Source**	**Amount Received**	
		R	
		R	
TOTAL			R

Do You Have Any Investments?: Yes ☐ No ☐ Value: _____

Do You Own Any Property?: Yes ☐ No ☐ Value: _____

Are You Currently Employed?: Yes ☐ No ☐

If "Yes": Permanent ☐ Casual ☐ Where Employed: _____

Contact Person: _____ Telephone No ☐☐☐☐☐☐☐☐☐☐

Suretyship

Applicants who are allocated a unit maybe required to have a family member or acquaintance sign a surety agreement with Algoa Bay Council For The Aged in the event of non payment of rentals or other fees.
Please supply the details of this person.

Title ☐☐☐☐ Surname: _____

First Names: _____ Relationship: _____

Identity Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

_____ _____

Postal Code: _____ Postal Code: _____

Medical

Do You Use Any Of The Following?:

Wheelchair: Yes ☐ No ☐ Walking Aid: Yes ☐ No ☐ Hearing Aid: Yes ☐ No ☐

Other *(Please specify)*:

_____

Do You Have A Medical Aid?: Yes ☐ No ☐

If "Yes": Medical Aid Name: _____ Membership Number: _____

It is compulsory for residents to have a funeral policy and proof of such will have to be supplied.
Please supply the following information

Do You Have A Funeral Policy?: Yes ☐ No ☐

Policy Underwriter: _____ Policy Number: _____

General

Do you smoke?: Yes ☐ No ☐ **Do you drink?:** Yes ☐ No ☐ Heavy ☐ Moderate ☐ Social ☐

Religion: _____ **Congregation:** _____

Leaders Name: _____ **Contact Number** ☐☐☐☐☐☐☐☐☐☐

Algoa Bay Council for the Aged has adopted a NO FIREARM POLICY. Should you be successful with your application you will have to provide proof that your firearm has been disposed of.

Do you own a firearm?:Yes ☐ **No** ☐ **Licence Number:** _____

Have you read the attached *Rules And Regulations*?: Yes ☐ No ☐

Do you agree to abide by the *Rules And Regulations*?: Yes ☐ No ☐

Are you a previous resident in one of our facilities?: Yes ☐ No ☐

Please note that previous residents will NOT BE GIVEN PREFERENCE on our waiting list.

Why do you want accommodation at Buffelsfontein Village?

_____

_____

Please supply us with the names and contact numbers of two Next of Kin

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

USE OF YOUR PERSONAL INFORMATION

When you apply for and receive our services you will be giving us your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 ("POPI"). We will take all reasonable steps to protect your personal information.
You authorize us to
(a) Process your personal information to
- (i) Communicate information to you that you ask us for.
- (ii) Provide you with supportive services.
- (iii) Verify the information you have given us against any source or database.
- (iv) Compile non-personal statistical information about you.

(b) Transmit your personal information to any donor, grantor or interested party so that we can provide supportive services to you and to enable us to further our legitimate interests including statistical analysis, report writing and credit control.
(c) Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your services on our behalf.

You acknowledge that this consent clause will remain in force even if services to you are terminated or cancelled.

_____ _____

Signed **Date**

Witnessed by Magistrate, Commissioner of Oaths or Minister of Religion

_____ _____

Signed **Date**

Personal Information (Partner 2)

Identity Number | | | | | | | | | | | | | | | | *Please attach a copy of your ID*

Title | | | | | Surname: _____

First Names: _____

Male ☐ Population Group (As on population register. ***For statistical reasons only***):

Female ☐ Asian ☐ Black ☐ Coloured ☐ White ☐

Marital Status: Widowed ☐ Divorced ☐ Separated ☐ Single (Never Married) ☐

Home Language: English ☐ Afrikaans ☐ Xhosa ☐ Other: _____

Telephone No (Home) | | | | | | | | | | | Cell | | | | | | | | | |

Other (Please specify) | | | | | | | | | | | _____

Email Address: _____

Current Accommodation (If Different To Partner)

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

_____ _____

Postal Code: _____ Postal Code: _____

For How Many Years: _____

Is Your Current Accommodation: Rented ☐ Owned ☐

If rented please supply the following information: Monthly Rental: _____

Landlord/Agent: _____ Telephone No | | | | | | | | | | |

Financial Details

Proof of Income and three (3) months' bank statements to be attached:

Income (Other Includes family assistance, salary etc):

Type Of Pension	Reference No	Amount Received	Total Monthly Income
		R	
		R	
Other Income	**Source**	**Amount Received**	
		R	
		R	
TOTAL			R

Do You Have Any Investments?: Yes ☐ No ☐ Value: _____

Do You Own Any Property?: Yes ☐ No ☐ Value: _____

Are You Currently Employed?: Yes ☐ No ☐

If "Yes": Permanent ☐ Casual ☐ Where Employed: _____

Contact Person: _____ Telephone No | | | | | | | | | | |

Medical

Do You Use Any Of The Following?:

Wheelchair: Yes ☐ No ☐ **Walking Aid:** Yes ☐ No ☐ **Hearing Aid:** Yes ☐ No ☐

Other ***(Please specify)*****:**

_____

Do You Have A Medical Aid?: Yes ☐ No ☐

If "Yes": **Medical Aid Name:** _____ **Membership Number:** _____

It is compulsory for residents to have a funeral policy and proof of such will have to be supplied.
Please supply the following information

Do You Have A Funeral Policy?: Yes ☐ No ☐

Policy Underwriter: _____ **Policy Number:** _____

General

Do you smoke?: Yes ☐ No ☐ **Do you drink?:** Yes ☐ No ☐ Heavy ☐ Moderate ☐ Social ☐

Religion: _____ **Congregation:** _____

Leaders Name: _____ **Contact Number** ☐☐☐☐☐☐☐☐☐☐

Algoa Bay Council for the Aged has adopted a NO FIREARM POLICY. Should you be successful with your application you will have to provide proof that your firearm has been disposed of.

Do you own a firearm?: Yes ☐ No ☐ **Licence Number:** _____

Have you read the attached *Rules And Regulations*?: Yes ☐ No ☐

Do you agree to abide by the *Rules And Regulations*?: Yes ☐ No ☐

Are you a previous resident in one of our facilities?: Yes ☐ No ☐

Please note that previous residents will NOT BE GIVEN PREFERENCE on our waiting list.

Why do you want accommodation at Buffelsfontein Village?

_____

_____

Please supply us with the names and contact numbers of two Next of Kin

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

Why do you want accommodation at Buffelsfontein Village?

_____

_____

Please supply us with the names and contact numbers of two Next of Kin

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

Name: _____ **Relationship:** _____

Telephone No ☐☐☐☐☐☐☐☐☐☐ **Cell** ☐☐☐☐☐☐☐☐☐☐

USE OF YOUR PERSONAL INFORMATION

When you apply for and receive our services you will be giving us your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 ("POPI"). We will take all reasonable steps to protect your personal information.
You authorize us to
(a) Process your personal information to
    (i) Communicate information to you that you ask us for.
    (ii) Provide you with supportive services.
    (iii) Verify the information you have given us against any source or database.
    (iv) Compile non-personal statistical information about you.
(b) Transmit your personal information to any donor, grantor or interested party so that we can provide supportive services to you and to enable us to further our legitimate interests including statistical analysis, report writing and credit control.
(c) Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your services on our behalf.

You acknowledge that this consent clause will remain in force even if services to you are terminated or cancelled.

_____ _____

Signed **Date**

Witnessed by Magistrate, Commissioner of Oaths or Minister of Religion

_____ _____

Signed **Date**

ALGOA BAY COUNCIL FOR THE AGED

MEDICAL REPORT

*This form to be completed by a **practising Doctor** or **clinic sister***

Applicants Name: _____

Applicant's general state of health is: _____

Applicant's mental state is: _____

Is applicant on psychiatric medication?: **Yes** ☐ **No** ☐

State conditions of the following:

Hearing: _____ **Eyesight:** _____

Heart: _____ **Blood Pressure:** _____

Lungs: _____ **Kidneys:** _____

Skeleton: _____ **Muscles:** _____

Skin: _____ **Abdomen:** _____

Digestion: _____ **Memory:** _____

Bladder Control: _____ **Bowel Control:** _____

State any particular ailments:

_____

_____

_____

Does applicant suffer from epilepsy?: **Yes** ☐ **No** ☐

Does applicant have any contagious or infectious diseases?: **Yes** ☐ **No** ☐

Can applicant perform the following without assistance?:

Eating: **Yes** ☐ **No** ☐ **Dressing:** **Yes** ☐ **No** ☐

Bathing: **Yes** ☐ **No** ☐ **Walking:** **Yes** ☐ **No** ☐

General comments in support of application:

_____

_____

_____

_____

_____ _____

Signed **Date**

Official Stamp

_____

Doctor or Clinic Sister's Name

Address: _____

_____

_____

_____

Postal Code: _____

ALGOA BAY COUNCIL FOR THE AGED

MEDICAL REPORT

*This form to be completed by a **practising Doctor** or **clinic sister***

Applicants Name: _____

Applicant's general state of health is: _____

Applicant's mental state is: _____

Is applicant on psychiatric medication?: **Yes** ☐ **No** ☐

State conditions of the following:

Hearing: _____ **Eyesight:** _____

Heart: _____ **Blood Pressure:** _____

Lungs: _____ **Kidneys:** _____

Skeleton: _____ **Muscles:** _____

Skin: _____ **Abdomen:** _____

Digestion: _____ **Memory:** _____

Bladder Control: _____ **Bowel Control:** _____

State any particular ailments:

_____

_____

_____

Does applicant suffer from epilepsy?: **Yes** ☐ **No** ☐

Does applicant have any contagious or infectious diseases?: **Yes** ☐ **No** ☐

Can applicant perform the following without assistance?:

Eating: **Yes** ☐ **No** ☐ **Dressing:** **Yes** ☐ **No** ☐

Bathing: **Yes** ☐ **No** ☐ **Walking:** **Yes** ☐ **No** ☐

General comments in support of application:

_____

_____

_____

_____

_____ _____

Signed **Date**

Official Stamp

_____

Doctor or Clinic Sister's Name

Address: _____

_____

_____

_____

Postal Code: _____