PLEASE READ THESE NOTES CAREFULLY BEFORE SUBMITTING YOUR ADMISSSION FORMS:

ALL FORMS MUST BE COMPLETED

- **ALL NEW RESIDENTS ARE TO BE TESTED FOR COVID-19 AND MUST HAVE A NEGATIVE RESULT BEFORE ADMITTANCE**
- **IS ISOLATION IS NOT POSSIBLE AFTER THE TEST – RESIDENT WILL BE PLACED IN ISOLATION IN SOFCA UNTIL THE RESULT IS RECEIVED**
- **FORMS ARE TO BE SUBMITTED TO SOFCA PRIOR TO ADMISSION FOR SCREENING PURPOSES**
- **MEDICAL REPORT CAN ONLY BE COMPLETED BY YOUR DOCTOR**
- **PAGE 5 & 7 MUST BE SIGNED BY A COMMISSIONER OF OATHS**
- **PAGE 16 & 17 ARE VOLUNTARY, BUT RECOMMENDED**
- **WE STRONGLY RECOMMEND THAT THE FLU VACCINE & PNEUMOCOCCAL VACCINE (for Pneumonia) IS ADMINISTERED BEFORE ADMISSION. THIS IS FOR THE SAFETY OF ALL RESIDENTS AND STAFF AT SOFCA**
- **2 X ID COPY OF NEW ADMISSION & ID COPY OF PERSON WHO SIGNS SURETY MUST BE ATTACHED**
- **3 MONTHS BANK STATEMENTS (SURETY SIGNATORY) MUST BE ATTACHED**
- **MEDICAL AID CARD MUST BE ATTACHED**
- **4 PASSPORT PHOTOS OF THE APPLICANT MUST BE ATTACHED**

THE HERMANUS FRAIL CARE CENTRE T/A SOFCA
1 Hospital Street, Westcliff - PO Box 321, Hermanus 7200
Tel: 028 312 3236 / 028 312 3276 email: sofcafrailcare@gmail.com

A

GENDER: **MALE / FEMALE** **ADMISSION NUMBER:**

SURNAME: _____ **FIRST NAME:** _____

DATE OF BIRTH:_____ **KNOWN NAME:** _____

ID NUMBER: _____ **MARITAL STATUS:** _____

PENSION FUND:_____ **PENSION NUMBER:** _____

MEDICAL AID FUND: _____ **MEDICAL AID NO:** _____

DATE ADMITTED: _____ **TIME ADMITTED:** _____

DOCTOR: _____ **TEL NO:** _____

PHARMACY: _____ **ALLERGIES:** _____

NEXT OF KIN

NAME: _____ **TEL NO:** _____ **EMAIL:** _____

POSTAL ADDRESS:_____

_____

RELATIONSHIP TO PATIENT: _____

OTHER FAMILY MEMBERS

NAME: _____ **RELATIONSHIP:**_____ **TEL NO:** _____

NAME: _____ **RELATIONSHIP:** _____ **TEL NO:** _____

PERSON/AUTHORITY RESONSIBLE FOR PAYMENT OF ACCOUNT

SURNAME: _____ **FULL NAMES:** _____

ID NUMBER: _____ **TEL NO:** _____

EMAIL: _____ **POSTAL ADDRESS:** _____

_____

RELATIONSHIP TO PATIENT: _____

NAME & ADDRESS OF EMPLOYER: _____

_____

SIGNED: _____

TO BE COMPLETED BY SOFCA STAFF AFTER DISCHARGE/DEATH:

UNDERTAKER: _____ **TEL NO:** _____

DATE DEATH/DISCHARGE:_____ **TIME DEATH/DISCHARGE:** _____

NAME & SIGNATURE:_____

SOFCA HERMANUS

APPLICATION OF ADMISSION

1. **SURNAME:** _____
2. **FULL NAME:** _____
3. **ID NO:** _____
4. **ADDRESS:** _____

   _____
5. **TELEPHONE NUMBER:** _____
6. **GENDER:** **Male / Female**
7. **DATE OF BIRTH:** _____
8. **AGE:** _____
9. **IF MARRIED, FULL NAME OF SPOUSE:**

   _____
10. **IF WIDOWED OR DIVORCED, SINCE WHEN?**

    _____
11. **HOME LANGUAGE:** _____
12. **RELIGION:** _____
13. **HOW MANY CHILDREN?**

    Sons: _____ How many married? _____

    Daughters: _____ How many married? _____

14. **WHERE ARE YOU LIVING NOW?** **MARK WITH AN X**

	YES	NO
WITH A CHILD	.....	.....
WITH DIFFERENT CHILDERN ALTERNATIVELY	.....	.....
WITH OTHER RELATIVES	.....	.....
HOTEL OR BOARDING HOUSE	.....	.....
IN A HOME FOR THE ELDERLY	.....	.....
OWN HOUSEHOLD	.....	.....

15. **WHAT IS YOUR PHYSICAL CONDITION?** **MARK WITH AN X**

	YES	NO
ARE YOU ABLE TO GET ABOUT WITHOUT DIFFICULTY	.....	.....
CAN YOU WALK ABOUT IN/OUTSIDE A BUILDING	.....	.....
DO YOU USE A MOBILITY WALKER, WHEEL CHAIR ETC.	.....	.....
DO YOU NEED ASSISTANCE WITH EATING/WASHING/DRESSING	.....	.....
ARE YOU MOSTLY CONFINED TO YOUR BED	.....	.....

WHAT IS THE STATE OF YOUR HEALTH / MARK WITH AN X

Good _____

Variable or rather poor _____

Poor _____

15. DO YOU SUFFER FROM ANY PARTICULAR AILMENT OR DISABILITY?
ie. Diabetes, Epilepsy, Blindness, Deafness etc.?
Please give details:

_____

16. WHAT WAS YOUR PREVIOUS OCCUPATION?

_____

17. WHAT IS/WAS THE MAIN OCCUPATION OF YOUR SPOUSE?

_____

18. PERSON/AGENCY RESPONSIBLE FOR YOUR FUNERAL COSTS?

_____

FUNERAL PARLOUR: _____

POLICY NUMBER: _____

19. DO YOU HAVE A WILL? YES / NO

NAME & ADDRESS WHERE HELD: _____

WHO IS THE EXECUTOR OF YOUR WILL? _____

TEL NO: _____

19. WHAT IS THE SOURCE OF YOUR INCOME?
(Documentary proof will be required when admitted)

	MONTHLY
Old Age Pension	R _____
Disability /Grant	R _____
Private Pension	R _____
Provident Fund	R _____
Interest on Investment	R _____
Properties	R _____
Other Sources	R _____
NETT MONTHLY INCOME	**R _____**

21. Have you appointed anyone to have power of attorney? If so, please give name, address and contact number:

_____

IF NOT, please nominate a person for us to arrange a meeting (give details below):

_____

20. State briefly the main reasons why you are seeking admission to SOFCA:

_____

_____

_____

24. When do you wish to be admitted?

Date: _____

25. Have you acquainted yourself with the rules and regulations of SOFCA? YES / NO

Certified copies of the following ID documents must be enclosed:

A) The Applicant

B) The Person who signed Surety

I HEREBY DECLARE THAT to the best of my knowledge the particulars furnished in this application form are true and correct. I understand, furthermore, if admitted to SOFCA, to abide by the rules and regulations of SOFCA which may be changed from time to time. I further undertake to pay the monthly fees. Should it be found that my income was wrongly given, I am prepared to refund the arrears fees payable as from such a date when the income was given.

_____ _____

SIGNATURE OF APPLICANT (OR ASSIGNEE) **DATE**

This Section for Commission of Oaths only:

SIGNED BEFORE ME AT _____

ON THIS _____ DAY OF _____ 20 _____

Name: _____ **Signature: _____**

COMMISSIONER OF OATHS / MINISTER OF RELIGION / MAGISTRATE

STAMP:

STATEMENT OF INCOME AND EXPENDITURE

	SELF	SPOUSE
TOTAL MONTHLY INCOME	**R**	**R**

PLEASE LIST ALL MONTHLY INCOME RECEIVED FROM: -
PENSIONS, ANNUITIES, TRUSTS & ALLOWANCES, SHARES, CAPITAL INVESTMENTS, RENTAL FROM PROPERTIES, OTHER:

FUNDS RECEIVED FROM:	SELF	SPOUSE
	R	R
	R	R
	R	R
	R	R
	R	R
	R	R
	R	R
TOTALS	**R**	**R**

FIXED PROPERTY OWNED (EG FARM, HOUSE)

ADDRESS:	PRESENT VALUE	BOND ARREARS
	R	R
	R	R
	R	R
	R	R
TOTALS	**R**	**R**

EXPENDITURE OF CONTINUOUS NATURE
(Documentary proof of expenditure must be furnished)

SPECIFY - EG. MEDICAL AID, TAX, BOND INSTALMENTS ETC	SELF	SPOUSE
	R	R
	R	R
	R	R
	R	R
	R	R
	R	R
TOTALS	**R**	**R**

STATEMENT OF INCOME AND EXPENDITURE cont..

APPLICANT:

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

_____ _____

SIGNATURE OF APPLICANT / AUTHORISED PERSON **DATE**

This Section for Commission of Oaths Only:

I certify that before administering the oath affirmation, I asked the deponent the following questions and recorded the answers as below in his/her presence.

.

A) Do you know and understand the contents of the declaration?

ANSWER: _____

B) Do you have any objection in taking the prescribed oath?

ANSWER: _____

C) Do you consider the prescribed oath to be binding on your conscience?

ANSWER: _____

SIGNED BEFORE ME AT _____

ON THIS _____ **DAY OF** _____ **20** _____

Name: _____ **Signature:** _____

COMMISSIONER OF OATHS / MINISTER OF RELIGION / MAGISTRATE

STAMP:

PLEASE ATTACH THE LATEST 3 MONTHS BANK STATEMENTS FROM THE PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT

AGREEMENT

Between **THE HERMANUS FRAIL CARE CENTRE T/A SOFCA**

And _____

(The Guarantor)

WHEREAS

A. _____ **(name of resident)** is a resident at SOFCA, and

B. Said resident is not able to pay SOFCA's full fees, and

C. The above-mentioned Guarantor is prepared to pay the difference between what the resident can pay and the full SOFCA fees payable.

D. The resident's fees are payable monthly in advance on receipt of invoice.
ONE MONTH REFUNDABLE DEPOSIT + THE CURRENT MONTHS FEES ARE PAYABLE ON OR BEFORE ADMISSION
In the event of death during the current month, no refunds will be given.

E. Fees not paid on due date shall attract interest @ 10% per annum.

NOW THEREFORE these terms and conditions under which these shortfalls will be paid are recorded as follows:

1.1 The full fees payable by the resident is in accordance with SOFCA's fees.

1.2 The Guarantor agrees to accept an annual increase in these fees as determined by the Board of SOFCA - increases will take place on 1st April each year.

1.3 The resident shall pay **R** _____

1.4 The Guarantor shall pay the shortfall between the amount the resident pays and the prescribed fees as per the terms set out in SOFCA's Surety.

SIGNED: _____

DATE: _____

SURETY

I/We, the undersigned

Name: _____

Physical Address: _____

_____

_____

Telephone No: _____

E-mail Address: _____

Hereby guarantee to stand surety for all costs, fees and extra expenses debited to the Residents' Fund, such as incontinence pads, SOFCA medical stock used, doctor's charges and interest.

Full name of resident:

_____

Against any payments due to SOFCA by him/her.

I/We declare to be fully acquainted with the content and meaning of such guarantee.

Signed at _____ on this _____ day of _____ 20 _____

FULL NAME: _____

ID NO: _____

SIGNATURE: _____

- **Notice in writing must be given one (1) month in advance of withdrawing a resident from SOFCA.**
- **In the event of death during the current month, no refund of fees for that month will be given.**

INDEMNITY

RESIDENT / FAMILY MEMBER FULL NAMES:

_____

I, the undersigned, do hereby indemnify, release and hold free from all liability THE HERMANUS FRAIL CARE CENTRE T/A SOFCA, its council, officers and/or employees, in respect of any claim I, or my estate, might have for damages arising from my admission and residence in any establishment controlled by THE HERMANUS FRAIL CARE CENTRE T/A SOFCA, or from any medical or other treatment I might receive during the period of my residence there, or as the result of any claim arising from the conduct or actions of any member of the council, officers or employees during my residence in the said establishment.

I, the undersigned, also indemnify SOFCA as well as any of their employees against any lawsuit, prosecution and/or actions that may arise as a result of injuries sustained or death during transport provided by SOFCA to any place.

Signed at HERMANUS on this _____ day of _____ 20 _____

FULL NAME: _____

ID NO. _____

SIGNATURE: _____

AS WITNESS

1. _____
2. _____

MEDICAL REPORT

MUST BE COMPLETED BY A MEDICAL PRACTITIONER

IN RESPECT OF AN ADMISSION TO A HOME FOR THE FRAIL AGED

1. **FULL NAME:**_____

2. **MEDICAL CONDITION** (HISTORY, SYMPTOMS AND PREVIOUS TREATMENT)

_____

_____

_____

_____

3. GENERAL PHYSICAL EXAMINATION
PHYSICAL & NUTRITIONAL STATE

_____

RESPIRATORY SYSTEM _____

CARDIOVASCULAR SYSTEM _____

BLOOD PRESSURE (CURRENT READING) _____

RENAL SYSTEM (CURRENT URINE TEST) _____

GYNAECOLOGICAL SYSTEM _____

ENDOCRINE SYSTEM _____

DIGESTIVE SYSTEM _____

MUSCULAR AND SKELETAL SYSTEM (STATE DEFECTS) _____

_____

4. **CENTRAL NERVOUS SYSTEM**

IF EPILEPTIC: STATE TYPE, SEVERITY, FREQUENCY OF ATTACKS AND RESPONSE TO TREATMENT:

_____

_____

_____

MENTAL CONDITION (INCLUDING MENTAL DEFICIENCY): STATE TYPE OF DEFECT AND MENTAL AGE, IF POSSIBLE AND WHETHER INSTITUTIONAL CARE IS ADVISABLE.

_____

_____

_____

(COMPLETE PSYCHIATRIC REPORT WHEN APPLICABLE)

IS THE APPLICANT FREE FROM INFECTIONS AND CONTAGIOUS DISEASES? _____

ANY OTHER CONDITIONS **NOT** IN CLASSIFICATION ABOVE?

_____

IS THE APPLICANT PERMANENTLY BED-RIDDEN? _____

IS THE APPLICANT INCONTINENT? _____

DOES THE APPLICANT USE INCONTINENCE PADS? _____
(TO BE PAID FOR BY APPLICANT OR RELATIVES)

CAN THE APPLICANT BE SATISFACTORILY CARED FOR BY A BASIC CARER? _____

DOES THE APPLICANT REQUIRE ASSISTANCE WITH DRESSING & MOBILITY? _____

DOES THE APPLICANT REQUIRE CONSTANT ASSISTANCE REGARDING FEEDING, MEDICATION & PERSONAL HYGIENE? _____

5. WILL FURTHER MEDICAL/SURGICAL TREATMENT IMPROVE OR CURE THE DISABILITIES DESCRIBED ABOVE? IF SO, STATE CLEARLY WHAT TREATMENT IS RECOMMENDED

_____

_____

_____

6. PRESENT MEDICATION (PLEASE INCLUDE ALL) OR ATTACH SCRIPT – PHARMACY USED?

_____

_____

_____

7. ANY OTHER MEDICATION OR SUPPLEMENTS?

_____

_____

8. ANY KNOWN FOOD OR MEDICATION ALLERGIES?_____

9. GENERAL REMARKS _____

_____

_____

_____ _____
MEDICAL PRACTITIONER NAME SIGNATURE

_____ _____
DATE OF REPORT STAMP

PSYCHIATRIC REPORT FOR ADMISSION TO SOFCA

NAME & SURNAME: _____

AGE: _____

GENDER: _____

PLEASE TICK AND / OR DESCRIBE CONDITIONS

MENTAL STATUS:	
Mentally Healthy	
Mentally Compromised	
Period of Condition and Treatment	
SEVERITY:	
SYMPTOMS:	
PSYCHOTIC BEHAVIOUR:	
Delusions	
Hallucinations	
Schizophrenia	
Psychotic behaviour due to a medical condition	
SEVERITY:	
SYMPTONS:	
NEUROPSYCHIATRIC ILLNESS:	
Dementia	
Delirium	
Neurological Illnesses	
Head Injury	
SEVERITY:	
SYMPTOMS:	
MOOD DISORDERS:	
Manic Behaviour	
Depressive Behaviour	
Suicidal Behaviour	
SEVERITY:	
SYMPTONS:	
PHYSICAL SYMPTONS	
Psychosomatic Behaviour	
Hypochondriac Behaviour	
Conversion Reaction	
SEVERITY:	
SYMPTONS:	

EATING DISORDERS	
Anorexia Nervosa	
Bulimia Nervosa	
SEVERITY:	
SYMPTONS:	
SUBSTANCE DEPENDENCE:	
Alcohol	
Drugs	
Other	
SEVERITY:	
SYMPTONS:	
PERSONALITY DISORDERS:	
Passive-Aggressive Behaviour	
Manipulative Behaviour	
Dependent Behaviour	
Anti-social Behaviour	
Borderline Personality Disorder	
Histrionic Behaviour	
Delusional Disorder	
Schizoid/Schizotypal Disorders	
SEVERITY:	
SYMPTONS:	
ANXIETY DISORDERS:	
Anxious Behaviour	
Phobias	
Obsessive Thoughts	
Compulsive Behaviour	
Adjustment Disorder (Adult)	
SEVERITY:	
SYMPTONS:	
OTHER BEHAVIOUR/PROBLEMS	
Sleep Disturbances	
Dissociative Disorders	
Withdrawn Behaviour	
Paranoid Behaviour	
Hostile Behaviour	
Sexual/Emotional/Physical Abuse	
SEVERITY:	
SYMPTONS:	

PSYCHIATRIC REPORT cont….

1. EXPECTED FUNCTIONING WHEN ADMITTED TO A FRAIL CARE FACILITY

Self-care & Continence:

_____

_____

Orientation with regard to time, place & person:

_____

_____

Ability to Communicate:

_____

_____

Emotions / Alertness:

_____

_____

Behaviour:

_____

_____

2. PROGNOSIS:

_____

_____

_____

_____

3. MEDICATION:

_____

_____

_____

_____

_____

_____

4. TREATMENT PLAN:

_____

_____

_____

_____

_____	_____	_____
AUTHORITY	**SIGNATURE**	**DATE**

WELFARE REPORT BY SOCIAL WORKER OR MINISTER IN RESPECT OF:

FULL NAME (APPLICANT): _____

PRESENT ADDRESS: _____

MARK WITH AN X

CAN THE APPLICANT	**YES**	**NO**	**LIMITED**
Keep house clean and tidy?			
Bath/Shower him/herself?			
Prepare and cook food?			
Dress him/herself?			
Walk and move without assistance?			
Feed him/herself?			

HIS / HER PHYSICAL & MENTAL CONDITION IS:

Healthy	Precarious	Weak	Signs of Senility	Mentally Alert	Forgetful	Disinterested

PRESENT ACCOMMODATION:

OWN HOUSE/FLAT	ROOM OWN	STAYS WITH FAMILY	IN HOSPITAL
RENTED HOUSE/FLAT	ROOM SHARED	STAYS WITH OTHERS	OLD AGE HOME
RENT/LODGING FEES	R (per month)		CARE CENTRE

STANDARD OF ACCOMMODATION:

GOOD	PASSABLE	WEAK	UNSUITABLE

PERMANANCE OF ACCOMMODATION:

TEMPORARY	UNCERTAIN	MUST VACATE

SOCIAL CIRCUMSTANCES: HOW IS HE / SHE CARED FOR?

WELL	GOOD	REASONABLE	NEGLECTED

SOCIAL CONTACTS:

SUFFICIENT AS TO:	**LIMITED TO:**	**ALONE FOR:**
FAMILY:	FAMILY:	DAY TIME:
FRIENDS:	FRIENDS:	NIGHTTIME:
		ALL THE TIME:

SOCIAL ADAPTABILITY AND BEHAVIOUR:

ADAPTS EASILY:	DEPRESSED:	PROBLEMATIC BEHAVIOUR:
ADAPTS WITH DIFFICULTY:	PLEASANT:	EXPLAIN:

PLEASE MOTIVATE THE REASON FOR ADMISSION TO SOFCA:

DATE: _____

SOCIAL WORKER / MINISTER DETAILS:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

The Living Will

TO MY FAMILY AND DOCTOR:

This declaration is made by me _____
(Full Name)

ID Number: _____

Address: _____

_____

If the time comes when I can no longer take part in decisions for my own future, let this declaration stand as the testament to my wishes.

If there is no reasonable prospect of my recovery from physical illness or impairment in which I am suffering continual pain or am incapable of ever again living a rational existence and when I am no longer capable of being consulted regarding my wishes, I request that I be allowed to die with dignity and not be kept alive by artificial means. I request that they administer whatever drugs necessary to keep me comfortable during this period even if it may reduce the length of my life.

This form is signed and dated by me in the presence of the two undersigned witnesses who at my request in my presence have given their names as witnesses.

Signed: _____

Date: _____

Witnessed by:

Signed: _____ Signed: _____

Name: _____ Name: _____

DO NOT RESUCITATE

I, _____
(Print Full Name & ID Number of Declarant)

Have discussed my health status with my doctor, _____
(Full Name of doctor)

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order and I understand its full import.

_____
Declarant's signature

_____
Date

_____
Print full Name & ID Number of person who signed for declarant, if applicable

_____
Signature

_____
Date

_____
Doctor's Signature

_____
Date

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud or undue influence.

_____
Print Full Name & ID Number of Witness

_____
Signature

_____
Date

On behalf of the management, staff and residents of SOFCA, we hereby extend to you a very warm welcome.

We would like to bring to your attention the following information so that everyone may work and live happily together.

SOFCA HOUSE RULES

Visiting hours are open for your convenience, although no visitors are allowed during mealtimes, and not later that 8pm (20H00) at night - special circumstances excluded.
Visitors are allowed in the rooms, except when the resident is being attended to by a caregiver.
Please show consideration and wait until the caregiver has completed her/his tasks before entering a room.

All new / first time visitors please report to the Sister-on-duty to introduce / identify themselves.

VISITING HOURS

MORNING:	**10:00**	**11:30**
AFTERNOON:	**14:00**	**16:30**
EVENING:	**18:00**	**20:00**

OUTINGS AND HOLIDAYS:

Residents must be accompanied by a responsible person should they wish to go out.
The Sister-in-Charge must be duly informed regarding any outing.
The resident must sign out and sign in again on return in the register at the Housekeeping Supervisors Station.
Medication must be issued and explained to the attending person.
The kitchen must be advised should a resident skip or meal - or whether a meal must be kept in case of late arrival.

Meals are only served in the rooms when a resident is ill or bedridden.

Special diets are only served if medically prescribed - ie. Diabetics, Hypertension or in the case of food allergies. Personal preferences are to be supplied by the family, or will be charged to the resident's account if supplied by SOFCA.

Please limit the amount of snacks kept in the rooms - label snacks and hand them in to the Sister-in-Charge, these will be kept in the fridge/kitchen as appropriate, please feel free to ask for your snacks as and when you want them.

No alcoholic substances are to be kept in the room.

Special requests regarding drinks or meals are to be directed to the Sister-in-Charge.

Should a resident be on or become dependent on **TUBE FEEDING (eg. Ensure or Supplements)** it will be for the residents account or must be provided by the family.

RESIDENTS AND/OR VISTORS ARE NOT ALLOWED IN THE KITCHEN DUE TO HEALTH AND SAFETY REGULATIONS.

CLOTHING AND VALUABLES:

All clothing must be machine washable and able to be dried in a tumble dryer.

All items must be CLEARLY marked with the resident's name, using a laundry marker pen.

We recommend valuable jewellery is kept to the minimum.

Residents are requested not to keep cash on their person but to hand it in to the Sister-in-Charge. A small safe Is available for limited amounts. Larger amounts are to be handed in to Reception where a larger safe is available.

Any valuables kept by the resident are his/her own responsibility.

SOFCA will not be liable for any loss or damage to personal items (clothing, linen, jewellery, furniture, walking aids or other special devices etc.)

- Please complete the **'items list'** on admission and update the list whenever necessary.
- Please ensure you have sufficient clothing for all seasons.

We recommend you have the following:

- 3 sets of pyjamas or night-clothes.
- Dressing gown & slippers
- Special detergents for personal laundry (soap powder and softener) will be for the resident's account should he/she not wish to use SOFCA's products.
- Laundry is done on a day-to-day cycle and returned to the rooms when ready.
- A small bedside rug is allowed, this should be washable and slip-proof.
- Personal furniture is limited to the minimum, a small TV set or radio is permissible.
  TV's must be licensed by the owner.
  Any installation fees or subscriptions (e.g. DSTV) are for the resident's account.
- Extra furniture is not allowed - over filling the room poses a safety hazard!
- No firearms, weapons or potentially dangerous items will be allowed.

MEDICATION:

All medication is to be listed and handed in to the Sister-in-Charge on admission. Thereafter, this will be controlled by the nursing personnel. Prescriptions will be obtained from a Medical Practitioner as and when necessary. No medication is to be kept in the resident's room. Should a resident require medical oxygen or any other medical / special nursing procedure e.g. catheterisation or intravenous infusion, whether chronically or in an emergency, it will be charged to the resident's account.

UNDER NO CIRCUMSTANCES MAY ANY VISITOR GIVE ANY MEDICATION (INCLUDING NATURAL REMEDYS) TO ANY SOFCA RESIDENT

CLEANING:

Rooms are cleaned daily.
Spills and splashes are to be reported to nursing or cleaning staff immediately.

REPAIR WORK AND MAINTENANCE:

All repair work in and around your room must be arranged through Management.
Please report any faults to the Sister-in-Charge.
Nails can only be inserted into walls with permission from the Sister-in-Charge.
If you require any additional changes to your room, please arrange with the Management.
Any unnecessary changes will be for the resident's account.
All electrical equipment must comply with SABS standards and is to be maintained by the resident (or family).
Any additional equipment for private use is with permission from Management only and is used at the owner's own risk.

TIPS OR LOANS:

NO TIPS, LOANS OR GIFTS OF ANY KIND ARE TO BE MADE TO ANY PERSONNEL FOR ANY SERVICES RENDERED. PLEASE CO-OPERATE FULLY IN THIS MATTER.
KINDLY CONSULT WITH THE MANAGEMENT WITH ANY QUERIES IN THIS REGARD.

ACTIVITIES:

A weekly programme is provided. Please contact the Sister-in Charge should any family member wish to assist as a volunteer. Contributions / ideas in this matter are also appreciated and may be discussed with the Management.

PHONE CALLS:

Please do not phone before 09:30 or during mealtimes to speak to the medical staff - the staff are busy allocating medication during mealtimes.

CHANGE OF ADDRESS / CONTACT DETAILS:

Next-of-kin must inform SOFCA immediately of any change of address or contact numbers.
If going on vacation, weekend away etc. please leave an emergency contact number with the Sister-in-Charge.

Postal Address:

SOFCA
PO BOX 321
HERMANUS
7200

Contact Numbers:

Landline Number (Office hours): 028 312 3236 / 028 312 3276
Cell phone Number: 076 814 3301
Please use the cell phone number for out-of-office hours and in the event of load shedding

Email addresses:

Nursing: nursing.sofca@gmail.com
Admin/Accounts: jennievorster@gmail.com
General Manager: sofcafrailcare@gmail.com

Please direct your queries to the correct department.

COMPLIMENTS AND COMPLAINTS:

We appreciate either compliments or complaints, as we strive to improve our service continuously.
Family members of residents are requested not to interfere with the daily working schedule of our staff members, nor may they personally instruct any staff member regarding their duties.
Should they have any reasonable complaints or suggestions, please direct them to the Sister-in-Charge.
Should they still be dissatisfied, please direct your complaints/suggestions in writing to the General Manger.

We expect and value good behaviour and encourage respect of personnel, residents, staff and visitors towards each other in order to maintain a healthy, happy and safe environment for all at SOFCA.

Thank you for your co-operation and support of SOFCA.

We wish you a pleasant stay with us.

PLEASE BRING THE FOLLOWING:

LINEN:

- 4 x SINGLE BED SHEETS
- 2 x PILLOWS
- 4 x PILLOWCASES
- 1 x DUVET INNER
- 2 x DUVET COVERS
- (OR) SINGLE COMFORTERS (IF YOU DO NOT WANT A DUVET)
- 2 x LARGE BATH TOWELS
- 2 x SMALL HAND/HAIR TOWELS
- 2 x FACE CLOTHS
- 1 x SMALL WASTE BASKET

PLEASE MARK ALL ITEMS CLEARLY WITH THE RESIDENT'S INITIALS AND SURNAME

TOILETRIES:

Please re-stock toiletries as necessary, hand in to the Housekeeping Supervisor every month for record purposes. Should a resident not have toiletries, SOFCA will purchase what is necessary and debit the amount to your account.

- SOAP & SOAP HOLDER (MARKED)
- TOOTBRUSH & TOOTHPASTE (MARKED)
- CONTAINER FOR DENTURES (MARKED)
- DENTURE CLEANER
- TALCUM POWDER
- DEODORANT
- HAND OR BODY LOTION
- SHAMPOO AND CONDITIONER
- SHAVING CREAM
- DISPOSABLE RAZORS
- ELECTRIC SHAVER (MARKED AND KEPT AT OWN RISK)
- TISSUES

IF YOU WISH TO DONATE EXTRA OF ANY OF THE ABOVE ITEMS FOR OUR LESS FORTUATE RESIDENTS, THIS WILL BE GREATLY APPRECIATED BY SOFCA

THIS LIST MUST BE COMPLETED AND SIGNED BY RESIDENT (OR FAMILY MEMBER) AND A SOFCA STAFF MEMBER ON ADMISSION

SOFCA WILL NOT TAKE RESPONSIBILITY FOR ANY ITEMS NOT LISTED BELOW

LIST OF PERSONAL ITEMS ON ADMISSION

Resident	Resident No.	Admission Date	Room No.	Checked in by

ITEM	QTY	REMARKS	ITEM	QTY	REMARKS
SHIRTS			APRON		
BLOUSES			JEWELLERY		
TOPS - LONG SLEEVE			GLASSES/SPECS		
TOPS - SHORT SLEEVE			HEARING AIDS 1/2		
T-SHIRTS			DENTURES		
TROUSERS			TOILETRY BAG		
SHORTS			LAUNDRY BAG		
SPENCERS			TOWELS		
VESTS			FACE CLOTHS		
BRA'S			SHEETS - FLAT		
PANTIES			SHEETS - FITTED		
UNDERPANTS - SHORTS			DUVETS - SINGLE		
UNDERPANTS - LONG			DUVETS - DOUBLE		
SOCKS			DUVET COVER (S)		
JERSEYS			DUVET COVER (D)		
DRESSES			BLANKETS		
SKIRTS			PILLOWCASES		
TRACK SUITS			RADIO		
SWEATERS			TV		
PJ'S - SUMMER			WHEELCHAIR		
PJ'S - WINTER			BED LAMP		
NIGHT GOWN - WINTER			CLOCK		
NIGHT GOWN - SUMMER			WALKING STICK		
SHOES			CRUTCHES		
SLIPPERS			WALKING FRAME		
HAIRBRUSH			OTHER		
COMB			OTHER		

SOFCA FEES:

FEES WITH EFFECT FROM 1 APRIL 2021

*	Shared Room (Monthly)	R 13,900
*	Daily Fee (including overnight)	R 660.00
*	Day Resident (7am - 7pm)	R 310.00

TEMPORARY RESIDENTS WILL BE CHARGED FOR THE DAY OF ADMISSION AND THE DAY OF DISCHARGE.

Our monthly fees include 24-hour professional care, all meals/snacks and full laundry service.
Please see below for extra charges **not included** in our monthly fee:

RESIDENT FUND

We extend credit to residents to enable them to obtain goods or services within or outside of SOFCA. The amount is debited to the next month's account.

MEDICAL AIDS

SOFCA does not liaise with Medical Aids and does not submit specified accounts.
You are responsible for the payment of your account.

HAIRDRESSER

Our hairdresser visits weekly or bi-weekly- charges vary. Please ask the Housekeeping Supervisor for the price list and indicate if you would like to make use of this service – this is not compulsory.

KIMBIES (Adult Diapers) & DISPOSAL

SOFCA can arrange to have kimbies delivered for your convenience - please note that SOFCA adds a service fee to the cost of the kimbies.
We have a set charge or R 158.00 (2021) per month for the disposal of kimbies by a registered disposal company.
Both of the above costs will be added to the account each month.

SOFCA MEDICAL STOCK

All medical stock purchased by SOFCA and used for the resident will be added to the account each month, this includes Accu-Check strips (for sugar), syringes, wound dressings etc…

ALL ACCOUNTS ARE STRICTLY PAYABLE IN ADVANCE

CASH PAYMENTS WILL INCUR AN ADDITIONAL BANK CHARGE OF R 30 PER R1,000