PLEASE READ THESE NOTES CAREFULLY BEFORE SUBMITTING YOUR ADMISSSION FORMS:

ALL FORMS MUST BE COMPLETED

- FORMS ARE TO BE SUBMITTED TO SOFCA PRIOR TO ADMISSION FOR SCREENING PURPOSES
- MEDICAL REPORT CAN ONLY BE COMPLETED BY YOUR DOCTOR
- PAGE 5 & 8 MUST BE SIGNED BY A COMMISSIONER OF OATHS
- PAGE 17 & 18 ARE VOLUNTARY, BUT RECOMMENDED
  THE DNR MUST BE SIGNED BY YOUR DOCTOR OR IT IS INVALID
- 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 - PLEASE PROVIDE PROOF
- 2 COPIES OF ID FOR THE NEW ADMISSION & OF THE PERSON WHO SIGNS SURETY MUST BE ATTACHED
- 3 MONTHS BANK STATEMENTS (SURETY SIGNATORY) MUST BE ATTACHED
- MEDICAL AID CARD OR PROVINCIAL HOSPITAL CARD MUST BE ATTACHED

THE HERMANUS FRAIL CARE CENTER 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: _____

MEDICAL AID FUND: _____

FIRST NAME:_ _____

MEDICAL AID POLICY NO:_____

KNOWN AS: _____

PENSION FUND NAME: _____

ID NUMBER: _____

PENSION FUND NO: _____

DATE OF BIRTH: _____

DOCTOR : _____

MARITAL STATUS: _____

DOCTOR TEL NO: _____

DATE ADMITTED: _____

PHARMACY: _____

TIME ADMITTED: _____

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: _____ **EMAIL:** _____

FIRST NAME: _____ **TEL NO:** _____

ID NUMBER: _____ **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 Y OR N** **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 Y OR N** **YES/NO**

ARE YOU ABLE TO GET ABOUT WITHOUT DIFFICULTY	_____
CAN YOU WALK ABOUT IN/OUTSIDE A BUILDING	_____
DO YOU USE A MOBILITY WALKER, WHEELCHAIR 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.? If yes, 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? PLEASE COMPLETE

_____

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: _____

20. WHAT IS THE SOURCE OF YOUR INCOME?
(Documentary proof will be required for screening pre-admittance) **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 as 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):

_____

22. **Briefly state the main reasons why you are seeking admission to SOFCA:**

_____

_____

_____

23. **When do you wish to be admitted? Date: _____**

24. **Have you acquainted yourself with the Admission Agreement & House Rules of SOFCA? YES / NO**

25. **Have you signed the Admission Agreement & House Rules 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:

For the family:

Please note below any likes, dislikes, allergies, preferences, or any other information you think might be useful for us to care for your family member to the best of our abilities:

_____

_____

_____

_____

_____

_____

_____

We have a hairdresser comes every 2 weeks; her prices are very reasonable.
R 80 men's hair / women's R 100 wash & blow / R 120 cut, wash & blow.
Perm & colour – price on request.
Please indicate if you would be interested in this service & how often:

Yes / No Service Required: _____Frequency: _____

We have a lady who comes every month to do hands & feet.
R 140 hands & feet / R 80 feet only / R 60 hands only / R 30 extra for nail polish.
Please indicate if you would be interested in this service and how often:

Yes / No Service Required: _____Frequency: _____

We have a tuck shop that is open daily – if your family member would like to make use of this, please set a monthly spend limit. This will be added to the account.

Yes/No Monthly Spend Amount: _____

STATEMENT OF INCOME AND EXPENDITURE

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

BREAK DOWN OF INCOME: 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

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

STATEMENT OF INCOME AND EXPENDITURE continued.

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 LAST 3 MONTHS BANK STATEMENTS FOR THE PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT.

AGREEMENT

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

And _____

(Name of 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 DEPOSIT + THE CURRENT MONTHS FEES (FULL OR PRO-RATA) ARE PAYABLE ON 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 the amount of: **R _____**

1.4 The Guarantor shall pay the amount of: **R _____ for fees + all extras as per statement**

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, doctor's charges and interest on behalf of:

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 and/or FAMILY MEMBER FULL NAMES:

_____

I, the undersigned, do hereby indemnify, release and hold free from all liability THE HERMANUS FRAIL CARE CENTER 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 CENTER 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
LATEST PRESCRITION TO BE ATTACHED

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) & 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 condition

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 continued.

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 COMPLETED: _____

SOCIAL WORKER / MINISTER DETAILS:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

The Living Will

TO MY FAMILY AND DOCTOR:

This declaration is made by me _____
Insert full name above

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: _____

Date: _____ Date: _____

DO NOT RESUCITATE

PLEASE NOTE THAT THIS FORM IS INVALID IF NOT SIGNED BY YOUR DOCTOR

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

Have discussed my health status with my doctor, _____
(Insert 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: _____

Doctor's Signature: _____

Date: _____

IF THE DECLARANT IS UNABLE MENTALLY OR PHYSICALLY TO SIGN, THE SECTION BELOW MUST BE COMPLETED:

Relationship to declarant: _____

Full Name: _____

ID Number: _____

Signature: _____

Date: _____

Attestation of Witness

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: _____

SOFCA ADMISSION AGREEMENT & HOUSE RULES

1. INTRODUCTION

SOFCA is an elder care facility that offers full time in-patient frail care and care for dementia patients.

SOFCA is a frail care home and not a hospital.

SOFCA fully complies with the requirements of the Older Persons Act 13 of 2006 ("the Act") and has strict house-rules that must be adhered to in order to ensure compliance with the Act and compliance with other ancillary laws applicable to institutions that care for older persons.

2. ADMISSION, FEES AND PAYMENTS

Prior to admission of any resident, the application form, complete with all attachments requested, must be completed, signed and handed/emailed to the office for pre-admission screening.

NO ADMISSION WILL BE DONE WITHOUT THE RELEVANT DOCUMENTS COMPLETED AND SIGNED.

The first month after admission is considered a probation period and should the resident, resident's family or friends/visitors fail to comply with these house-rules, the admission agreement may be cancelled with 1 (One) day notice and the resident be ordered to leave the premises immediately.

Fees are calculated on a monthly basis, which are payable in advance on receipt of your monthly invoice from SOFCA.

The fees are set out in the admission form. Fees are adjusted on the 1st of April each year, and the increase is dependent on inflation and other factors. The annual increase is at the discretion of the Board/Management and shall be always binding on all residents.

All fees must be paid every month, even if the resident is absent from the facility during such calendar month for any reason whatsoever.

3. BANKING DETAILS

Account Holder: SOFCA
Bank: Nedbank, Hermanus
Account number: 1470014343
Branch Code: 198765
Deposit Reference: Account number on invoice/statement

4. NOTICE AND TERMINATION

If a resident or his/her family wishes to terminate the Admission Agreement, management must be given 1(one) month written notice of such termination. The resident/family/surety shall remain liable to pay the fees for the notice period and no deposit paid shall be off set against any fees payable.

Management reserves the right to immediately terminate the Admission Agreement if the **resident and/or family and visitors** become a nuisance to fellow residents, and/or refuse to abide by the House-rules and/or fail to make prompt payment of accounts received. Under such circumstances the resident shall vacate the facility within 14 (fourteen) days of being notified in writing of such termination.

No refunds will be paid in the event of termination in terms of above.

Prior to leaving the facility the resident/surety are liable to pay all outstanding accounts, failure of which the resident/surety will be held liable for legal costs incurred for the collection of such outstanding fees.

5. VISITING HOURS

Visiting hours are open for your convenience, although no visitors are allowed during mealtimes. Visitors are allowed in the rooms, except when a 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 introduce yourself to the sister-on-duty or the nursing manager.

All visitors enter SOFCA at their own risk as we accommodate dementia residents who can be difficult at times. No visitors may approach any resident who is not their family member.

Visiting hours:

Morning:	09:30	11:45
Afternoon:	14:15	16:45
Evening:	18:15	20:00

6. NURSING CARE AND MEDICATION

SOFCA complies with staff / resident ratios as required in the regulations of the Act. If a resident or family require extra personal nursing care or constant supervision for a resident this matter must be discussed with the senior nursing staff. If such request is approved the resident/family/surety shall be liable for the cost of the additional personal caregiver on top of any normal fees that are payable.

It is the responsibility of the resident or family member to ensure that the Nursing Manager is advised in writing of all special requirements as prescribed relating to the resident which includes special medical treatment, exercise and diets.

On admission all medical prescriptions & medication must be handed to the senior nursing staff on duty. Thereafter, all medication will be controlled by the nursing personnel. Residents are not allowed to keep any medication or to self-medicate. If a resident has a specific need for medication other than medication prescribed for minor ailments such as a headache or colds, same must be conveyed to the nurse on duty who will dispense medication as per the instruction of the Nursing Manager. Under no circumstances may family members medicate a resident (including natural remedies) without the prior knowledge of the Nursing Manager. All non-prescription medications dispensed from SOFCA stock will be charged to the resident's account.

HGT & urine testing is conducted monthly on all residents – the cost of the test strips will be charged to the residents' account.

It is understood that residents will visit doctors, hospitals and/or clinics on a regular basis. All such visits must be reported to the nursing staff before the appointment. Upon the return of the resident all prescriptions and medication received must be handed into the senior sister on duty and the Nursing Manager must be advised of any change in treatment regiments.

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, all medical stock used will be charged to the resident's account.

No staff member may be sent to purchase any medication.

Residents who belong to a medical aid are advised to register with Alex Grant or Onrus Pharmacy, who will deliver their medication to SOFCA.

Although SOFCA does have transportation facilities, it is first and foremost the responsibility of family to transport residents to and from hospitals, clinics and doctors. In the event of an emergency SOFCA reserves the right to call on ambulance services to move a resident to a medical facility, the cost of which shall be borne by the resident/family/surety.

SOFCA reserves the right to move a resident from any specific section to another section in accordance with the resident's medical condition without prior notice to family. This is to ensure best practises and care.

7. TREATMENT OF RESIDENTS AND STAFF MEMBERS

SOFCA has a zero-tolerance policy insofar as ill treatment of residents is concerned and such behaviour will not be tolerated. Any incident of ill treatment must immediately be reported to the relevant area manager.

Management expects that residents/family members and visitors shall treat all staff members with dignity and respect and any form of harassment, swearing at, racial remarks and especially violent behaviour towards staff members will not be tolerated. A breach of this clause goes to the core of these House Rules and shall be considered as a material breach and the Management reserve the right to immediately cancel the Resident Agreement.

It is important to note that family members/visitors shall adhere to the rules of treatment of staff and residents. Under no circumstances may family members/visitors intervene or interfere or confront staff members or residents regarding any situation whatsoever. If a family member/visitor is dissatisfied with any treatment or have knowledge of ill treatment of a resident, it is their responsibility to immediately report this to the senior sister on duty so that it can be investigated, and proper disciplinary steps taken. If a family member/visitor does not comply herewith, access to the facility by such family member/visitor can be denied and management strictly reserves the right of access. Continuous disregard of this rule can lead to the termination of the Admission Agreement and the resident will be forced to vacate the facility as stipulated above.

No tips, loans or gifts of any kind are to be made directly to any staff members under any circumstances. Please co-operate fully in this matter.

8. GRIEVANCE PROCEDURES

All grievances shall be directed to the relevant area manager. It is preferred that any grievances are submitted in writing by email/letter/WhatsApp message.

The manager shall within 7 (seven) working days provide written feedback to the resident or family member/visitor of the outcome/solution of the grievance.

If no solution or suitable outcome has been reached the manager shall appoint an independent mediator to investigate the grievance and the finding of the mediator shall be binding on all parties concerned.

9. PERSONAL EFFECTS

All personal effects must be recorded in the 'Items List' on admission and updated when changes are made to the inventory of the resident.

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-on-duty, there is a small safe available for limited amounts. Larger amounts or other valuables can be handed into reception where a larger safe is available. Any valuables kept by the resident are his/her own responsibility and SOFCA does not accept responsibility for them.

There is a laundry facility available at SOFCA. All clothing washed at the laundry must be clearly marked. SOFCA does not take responsibility for unmarked clothing going missing. All clothing must be machine washable and able to be tumble dried.
Please ensure you have sufficient clothing for all seasons.

Residents must provide their own duvets, sheets and blankets – all of which must be clearly marked and identifiable.

Radio's, TV's and music may not be played loudly, especially after 21:00 or in such a way as to cause a nuisance to other residents. If the resident is hearing impaired, please notify management so that appropriate measures can be taken.

SOFCA does not supply toiletries or clothing.
SOFCA will not be liable for any loss or damage to personal items.

10. MAINTENANCE & CLEANING

Rooms are cleaned daily. Spills & splashes are to be reported to the nursing staff or housekeeping supervisor immediately.

All repair work in and around your room must be arranged through management.
Report any faults to the nursing manager.

Nails can only be inserted into the walls with permission from the maintenance staff.

All electrical equipment must comply with SABS and is to be maintained by the resident/family.

Any additional equipment for private use is with permission from the management and is used at the owners own risk.

11. OUTINGS AND HOLIDAYS

Residents must be accompanied by a responsible person should they wish to go out.
The resident/family member/visitor must sign out in the register at reception and sign in on return to SOFCA.

Medication for the required amount of time will be issued by the sister-in-charge and explained to the responsible person.

The kitchen must be advised should a resident skip a meal – or whether a meal must be kept in the case of late arrival.

If a resident is out for a day excursion or visit, they are to return to the facility before 18:45. The main doors to the facility will be closed and locked at 19:00. If a resident wishes to return after 19:00 special arrangement must be pre-made with the office so that appropriate arrangements can be made.

12. MEALS

SOFCA serves meals to all residents and is not a self-catering facility. 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. Limit the number of snacks kept in the rooms or label snacks and hand them into 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.

Meals are only fed to residents in the dining hall and if the resident has become bedridden or is unable to attend the dining hall the sister on duty will instruct a care worker to assist a resident in taking his/her meal.

No alcoholic substances are to be kept in the room.

Special requests regarding drinks/meals are to be directed to the nursing manager.

Should a resident be on or become dependent on TUBE FEEDING (e.g. Ensure or other supplementary meals) it will be for the residents account or must be provided by the family.

Residents and/or visitors are not allowed in the kitchen due to Health & Safety regulations.

Meals are served at the following times:

Breakfast:	08:30
Morning tea:	10:00
Lunch:	13.00
Afternoon tea:	15:00
Supper	17:00

13. PHONE CALLS

No calls can be transferred to the frail care before 09:30 in the morning or during mealtimes. Office hours are 07:00 to 16:00 Monday to Friday. Outside of office hours – if the landline is unavailable, call or WhatsApp the cell phone.

14. CHANGE OF ADDRESS/CONTACT DETAILS

Next-of-kin must inform SOFCA of any changes to personal details.

If going on vacation, weekend away etc. please leave an alternative emergency contact number with the nursing manager/sister-on-duty.

15. POPI ACT

All residents/family members/visitors are expected to adhere to the POPI Act and to respect the privacy of SOFCA's residents and staff members.

16. SMOKING POLICY

NO SMOKING IS ALLOWED INSIDE THE BUILDING AT ANY TIME

Smoking is only allowed in demarcated areas outside the building and residents who smoke must ensure that cigarette butts are properly put out and discarded in the provided containers.

Any resident found smoking in a room will be warned and cigarettes will be confiscated due to fire hazards. Continued breach hereof could lead to the termination of the Resident Agreement.

17. SOFCA CONTACT DETAILS

Postal Address
SOFCA
PO BOX 321
HERMANUS, 7200

Phone: 028 312 3236/3276
Cell: 076 814 3301 (for use outside of office hours)

Email:
Nursing manager: sofcanursingmanager@gmail.com
Sister-on-duty: nursing.sofca@gmail.com
Admin/accounts: jennievorster@gmail.com
General manager sofcafrailcare@gmail.com

Ensure queries are directed to the correct department.

18. COMPLIMENTS & COMPLAINTS

We appreciate either compliments or complaints, as we strive to improve our service continuously.
Should you have any reasonable complaints or suggestions, please direct them to the nursing manager.
Should you still be dissatisfied, direct your complaints/suggestions in writing to the general manager.

I declare that I have read and understand this agreement. I undertake to abide by the house rules and understand that by breaking these rules this agreement may be terminated.

Read and signed by: _____
Name & Signature

Date: _____

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 toiletries for our less fortunate residents, this will be greatly appreciated by SOFCA.

THIS LIST MUST BE COMPLETED AND SIGNED BY THE RESIDENT (OR FAMILY MEMBER) AND A SOFCA STAFF MEMBER ON ADMISSION. SOFCA WILL NOT TAKE RESPONSIBILITY FOR ANY ITEMS NOT LISTED BELOW. PLEASE UPDATE AS NECESSARY

LIST OF PERSONAL ITEMS ON ADMISSION

Resident Name	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 2024

- Shared Room (Monthly) R 17,350
- Disposal Fee R 195.00

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 spent is added to the following months' account.

HAIRDRESSER / HANDS & FEET CARE / TUCK SHOP

See Page 6

KIMBIES (Adult Diapers) & DISPOSAL

SOFCA can arrange to have kimbies delivered for your convenience - the account will be sent to you directly for you to settle with TLC.
We have a set charge or R 195.00 per month for the disposal of kimbies by a registered disposal company.

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…

MEDICAL AIDS

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

ALL ACCOUNTS ARE STRICTLY PAYABLE IN ADVANCE

FOR YOUR INFORMATION: SOFCA DOES NOT HAVE CARD FACILITIES

CASH PAYMENTS WILL INCUR AN ADDITIONAL BANK CHARGE OF R 30 PER R 1,000