KENSINGTON HOME FOR THE AGED
("KOAH")
Registration No. 026-367-NPO

PO Box 809, Maitland, 7404
Physical Address: Cnr 12th Avenue & Avro Avenue, Kensington, 7405
GPS: 90 Avro Avenue, Kensington, 7405
Tel: 021 593 2274/85
Email: koah@mweb.co.za
Website: www.kenshome.co.za

APPLICATION FOR RESIDENCY

KINDLY TELEPHONE ANY OF THE ABOVE NUMBERS FOR AN APPOINTMENT

IMPORTANT INFORMATION TO BE NOTED

The following are important points that should be studied carefully.

1. **Registration**
   A Non-Refundable deposit of R100 must be paid when handing in the application form.
   A certified copy of the applicant's identity document must accompany the application.

2. **Clothing and Toiletries**
   Residents and their families are responsible for the supply of personal toiletries and adequate and sufficient clothing **properly marked** with the resident's name. (Use permanent marker)

3. **State Pension**
   For ease of administration, state old age pension(SASSA) will be transferred to KOAH.

4. **Notice Period**
   Should a resident wish to terminate his/her residency, one calendar month's written notice is required.

5. **Liability**
   Whilst KOAH will take every precaution possible, when taking up residence, the resident shall do so entirely at his/her own risk insofar as any loss, damage of property or personal injury not covered by any insurance policy, taken out by KOAH.

6. **Harmony**
   As you will undoubtedly appreciate, the maintenance of an amicable relationship between residents is of utmost importance if a harmonious lifestyle is to be achieved. Any person whose behaviour disrupts or adversely affects other residents and the ambience we strive to attain could result in the discharge of such a person.

7. **Furniture**
   This is negotiable between you and the Home Manager.

   Notes:
   - Each page must be initialled.

FEES

Up to 69 years	
Description	**Amount**
SASSA Pension	1890.00
Short-Fall	1250.00
Registration Fee	100.00
Initial 1st Month	R 3240.00
Monthly Fees	R 3140.00

70 years plus	
Description	**Amount**
SASSA Pension	1910.00
Short-Fall	1250.00
Registration Fee	100.00
Initial 1st Month	R 3260.00
Monthly Fees	R 3160.00

Resident's Details

Surname: ______________________ Gender: M ☐ F ☐

Full Names: ______________________

Maiden Name: ______________________

Address: ______________________

____

____

ID Number: ______________________ Date of Birth: ______________________

Marital Status: Married ☐ Widowed ☐ Divorced ☐ Single ☐

Language: Eng ☐ Afr ☐ Xho ☐ Other: ______________________

No of Children: ________ Sons: ________ Daughters: ________

Religious Affiliation: ______________________

Religious Leader: ______________________ Contact No:

Do you receive a State Pension/Grant? (Y/N): _____ Amount: ______________________

Next of Kin/Responsible Person/s Details

Name	Relationship	Contact
1. Email:		
2. Email:		
3. Email:		
Address of 1(if different to Resident's)		

(Name of person responsible for account must be entered in block 1)

Funeral Arrangement

Name of Funeral Home: ____________________

Contact No: ____________ Policy No: ____________

Cremation/Burial: ____________________

If you have no policy, please state who is responsible for making funeral arrangements and the cost thereof:

Name: ____________________

Address: ____________________

Contact No: ____________ Cost: ____________

Medical Info

Are you a Government Patient: ☐ Private Patient: ☐

Which Hospital/Day Hospital: ____________________

Name of Local Doctor: ____________ Contact No: ____________

Do you belong to a Medical Aid Scheme (Y/N): ______

Name of Scheme: ____________ Contact No: ____________

Member No: ____________

Other Information

Attended Previous Institute **Y / N**

If Yes – Name of Institute: ____________________

Measure of Self-Dependence

	YES	NO
Do you suffer from any specific ailments e.g. diabetes, epilepsy, deafness, etc		
If YES, please elaborate:		

* Can you walk outside without difficulty?		
* Can you walk indoors without difficulty?		
* Can you bath/shower without help?		
* Can you dress without help?		
* Can you have meals without help?		
* Can you wash without help?		
* Are you mostly bedridden?		
* Have you control over bladder and bowel functions?		
* Are you wheelchair bound		
* Other		
*		
*		

Family Responsibility/Agreement

It is important that all family members of prospective KOAH residents become aware of the high overall cost of care in a frail aged home with the 24 hour nursing service, meals, laundry and many other facilities that are provided. The sole sources of income to meet the cost are rentals payable by the resident and a state subsidy. In many instances, the total income so derived does not equal the unit cost of a resident's accommodation and, like other welfare organisations throughout the country, KOAH has no way of providing for the shortfall other than to pass it on to family members.

You should be aware therefore of the fact that signed undertaking to meet any shortfall between unit cost and income is required from family members, prior to admission of a new resident to KOAH. Family members need also to be aware that in many instances it is necessary for them to render financial assistance to a resident for other personal needs such as clothing, medicines, toiletries and the like.

I, ______________________________________ (full names please) hereby acknowledge having received notice from KOAH to the effect that family members are required to meet the difference (shortfall) between the Unit Cost per resident(excluding Medical and Other* cost) and the "Total Income(SASSA Grant) derived by KOAH in respect of the resident concerned.

Eg: Unit cost(R3130.00) – SASSA Grant(1880) = Shortfall(R1250) Other*: Adult Diapers, Medical fees & Personal needs etc.

Photo Consent:
From time-to-time we are required to post photos of residents on social media and/or our website for promotional purposes. By signing this agreement you consent to the use of photos in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying Kensington Home For The Aged in writing.

____ ______________________________

Signed Date

Application Approved By:	Signature:	Date:

MEDICAL REPORT

To be completed by **MEDICAL PRACTITIONER**

PATIENT'S FULL NAME ____________________

AGE: __________ SEX: __________ WEIGHT: __________

1. Serious medical conditions (eg previous coronary or CVA) ____________________

____

2. Operations (eg Hysterectomy, hip replacement, heart by-pass) ____________________

____

3. Other (eg pacemakers) ____________________

____

4. General examination:

4.1 General physical and nutritional state: ____________________

____

4.2 Respiratory system: ____________________

4.3 Cardio vascular system: ____________________

4.4 Blood pressure: ____________________

4.5 Genitor-urinary system (Urine to be tested): ____________________

4.6 Digestive and other abdominal systems: ____________________

4.7 Hernia: ____________________

4.8 Muscular and skeletal systems (state defects) ____________________

____

4.9 General nervous system (In epilepsy and response to treatment: ____________________

____

Severity, frequency of attacks and response to treatment: ____________________

____

4.10 Mental condition (list any previous psychotic or psycho neurotic episodes with dates if possible:

____

____

4.11 Skin and special senses:

____

4.12 Circulation-pulses: ____________________

4.13 Any other condition not included in classification above: ____________________

____

5. Is applicant free from infectious and contagious disease (Be as accurate as possible):

____

6. Has the applicant suffered from Tuberculosis in the past? ____________________

Is the applicant currently free of Tuberculosis? ____________________

If not, are they undergoing treatment? ____________________

7. Does the applicant require assistance regarding mobility, dressing and undressing, feeding or personal hygiene:

____

____

8. Current medication

8.1 Chronic medicines – strength and dose: ____________________

____

____

8.2 Are medicines private or state: ____________________

9. Allergies: ____________________

____

10. How long have you known the patient? ____________________

Date: ____________________

(PLEASE NOTE: This medical is only valid for 3 months)

____________________ ____________________

NAME of MEDICAL OFFICER **SIGNATURE of MEDICAL OFFICER**

____

TEL NO

STAMP

INDEMNITY FORM

NAME OF RESIDENT: ____

ID NUMBER: ____

I, the undersigned do hereby state and agree that:

1. THE KENSINGTON HOME FOR THE AGED("KOAH") is hereby indemnified against any claim of whatsoever nature, especially in lieu of pensions or grants payable on the death of, or termination of resident.
2. I am further aware that whilst KOAH will take every precaution possible on taking up the resident at KOAH, the resident shall do so entirely at his/her own risk insofar as it concerns any loss, damage or personal injury not covered by any insurance policy taken out by KOAH.
3. I have read and understand this Acknowledgment and Agreement.

SIGNED AT ________________________ ON THE _______ DAY OF _________ 20___

____

SIGNATURE of Applicant

AS WITNESSES:

1. NAME	SIGNATURE
2. NAME	SIGNATURE

RESIDENT'S MEMORANDUM OF UNDERSTANDING

Entered into between

KENSINGTON HOME FOR THE AGED

(Herein after referred to as "KOAH")

AND

____

(Herein after referred to as "the resident" or "responsible party")

ID Number:___________________________

Reg. No. 026-367-NPO
Corner 12th & Avro Avenue, KENSINGTON, 7405 * P.O Box 809, MAITLAND, 7404
Telephone: 021 593-2274/2285 * E-mail: koah@mweb.co.za

RESIDENT'S MEMORANDUM OF UNDERSTANDING

This agreement is entered into by and between Kensington Home for the Aged (KOAH) and____

("Resident") and/or ("Responsible Party"), the authorised representative and guarantor of the Resident.

This ________ day of ______________________ 20________.

The Parties Hereby Agree as Follows:

In compliance with all the terms and conditions set forth herein by the Resident and/or Responsible Party, KOAH agrees to accept the Resident and provide care and services as set forth in the Agreement commencing __________________________ once all financial obligations have been met.

The Resident and/or Responsible Party specifically acknowledge and understand that both parties are jointly and severely liable and contractually obligated for any and all charges and fees due to KOAH. The responsible party fully acknowledges this fact and specifically agrees to undertake financial responsibility for all obligations incurred by the Resident, which is outside the scope of the agreement.

The Management of this home has agreed to exercise such responsible care toward the Resident as his/her known condition may require; however KOAH will not be held liable for accidents due to an unsafe act by the resident.

The Resident and/or Responsible Party acknowledge that non-payment may be treated by KOAH as a material breach of this Agreement.

The rate of R___________ for room and board and personal care services of Resident, is payable monthly.

Payment is to be made to the facility no later than the last working day of each month. The Resident and/or Responsible Party agree to pay KOAH promptly.

KOAH shall arrange for the routine ordering of prescription and/or medical supplies, except when otherwise specified by the Resident and/or Responsible Party. This decision shall be noted on or

before the day of admission. Invoices are payable upon submission for ordered items directly to the resident and/or Responsible Party.

The Resident and/or Responsible Party agrees to pay as billed, unless the Resident is covered for this cost by Medicare, Medicaid or private insurance for the following:

1. For physician's visit upon request and when necessary.
2. For consultation services that may be ordered by the attending Physician, such as Physical Therapy, Speech Therapy, Dental care, Podiatrist care of any other Specialty that may become necessary.
3. For all prescription medications ordered for the Resident by the Physician.
4. Be responsible for all charges, in full, in the event that Medicare or a private insurance denies a claim.

The monthly Fee may change annually and thirty (30) days advance written notice must be given to the Resident and/or Responsible Party.

Termination of this Agreement is dependent upon thirty (30) days written notice by either party. At this time, any available balance of funds will be refunded. There will be no refund for unused days if the Resident leaves the facility before the end of the thirty (30) day notice.

Terms and Conditions of this Agreement:

1. A security deposit equal to a thirty (30) day payment shall be made in advance at the time of the signing of this Agreement. Payment shall be made monthly in advance thereafter. If the date of admission is on or after the 15th of the month, payment shall include the balance of the month plus the thirty (30) day in advance payment.

2. Within sixty (60) days of discharge or upon termination of this Agreement, the Resident and/or Responsible Party shall receive a refund, if applicable, of any amount due minus applicable charges through to the effective date of discharge.

3. The Resident and/or Responsible Party accept full financial responsibility for, and agree to pay, the full amount charged by KOAH. Failure or refusal to pay any amounts charged under the terms of this Agreement will result in a service charge of one (1%) percent of the outstanding balance due monthly.

In addition, all reasonable charges, expenses, attorney's fees, and court costs for collection and/or litigation and related costs if such action is deemed necessary to collect any amounts due, shall be the responsibility of the Resident and/or Responsible Party.

4. KOAH will use the services for the Day Hospital for all residents; however any other professional services eg Specialists will be for the resident's personal account.

5. KOAH operates in compliance with the terms of Older Persons Act (13) of 2006 and does not discriminate against any person with respect to age, sex, race, color, religion, creed, national origin or disability in the admission and treatment of Residents, the accommodations provided, the use of equipment or the assignment of personnel to provide services.

6. Under no circumstances shall KOAH without written authorisation of the Resident and/or Responsible Party release any information concerning the Resident to other medical facilities, insurance companies, federal and/or state agencies and regulatory bodies, concerning any illness of, or treatment rendered the Resident. The facility will comply with all applicable laws and regulations to ensure that confidentiality is maintained.
7. Should the Resident require medical attention, KOAH will notify the Resident's Attending Physician as designated by the Resident and/or Responsible Party. If the Attending Physician is not available, Resident hereby authorizes KOAH to call another physician for Resident, and any expenses shall be billed to the Resident and/or Responsible Party, unless otherwise covered by insurance or other third party payer.

Should transfer out of the facility be necessary and the Resident's Attending Physician or alternate physician is unavailable, the Facility Medical Staff Supervisor will be responsible for making the final decision for transferring to a general hospital, mental hospital, or other facility. Such transfers shall be affected as early as possible. The next-of-kin will be involved in the decision making process, where possible, and will be notified immediately of such a decision and necessary action at the time of occurrence.

KOAH reserves the right to discharge any resident for reason, but not limited to the following:

a. Presenting a danger to himself or other residents.

b. Repeatedly violating rules and regulations of KOAH Home after being advised of them in writing.

c. Failure to pay Monthly Fees on a timely basis, as billed.

d. Medically unstable condition and/or special health problem and a regimen of therapy that cannot be appropriately developed or provided in the comprehensive care home environment.

e. Any other cause to ensure the safety and wellbeing of the resident or others.

Even though KOAH will exercise reasonable care toward the Resident's belongings, they are in no manner responsible for the items in the Resident's possession and for the items that they hold for the Resident. They assume no responsibility for such and no bailment should be deemed to be created. KOAH may, at its discretion, dispose of any and all of the Resident's items that are left more then ten (10) days after final discharge.

The Resident and/or Responsible Party agree to abide by the rules and regulations of KOAH.

By signing this Agreement, the Resident and/or Responsible Party acknowledge that they have read, understand and accept all of the terms and conditions set forth in this Agreement.

I/we agree to be responsible and to pay, at the time stipulated, all sums due and owing to KOAH for the above-named Resident in accordance with all the terms and conditions set forth in this Agreement.

Parties acknowledge that all representations and promises made are contained in this document and contains in its entirety understanding that exists between the parties and that modification to this agreement must be in writing and signed by all parties.

I/we hereby certify and represent to the best of my/our knowledge under penalties of law, that all statements herein are true, accurate and complete based upon reliable statements and information contained and supplied by me/us as part of the Admission Process. If any information furnished or represented by me/us in connection with this Application or contained herein should prove false, inaccurate, untrue or misleading in any material respect (as determined solely by KOAH), then KOAH may terminate this Agreement upon thirty (30) days written notice to Resident and/or Responsible Party. Upon such termination, KOAH may discontinue providing all services to Resident and the Resident will be required to vacate the facility.

BANKING DETAILS

Account Name	**Kensington Home For The Aged**
Bank Name	**First National Bank**
Account No	**50270767154**
Branch Code	**250655**
Reference	**“Resident Init & Surname”**

Signed this __________ day of ____________________________ 20 _____

____
Signature *(of the person responsible for the resident and payment)*

____
Signature of Witness

KENSINGTON HOME FOR THE AGED

House Rules – Code of Conduct

The Aims of rules and regulations are intended to ensure that the property and all residents are protected while in our care.

1. Residents must keep themselves clean and tidy-within their abilities.
2. Residents are to assist in keeping the living quarters/garden clean to the best of individual abilities.
3. Residents may not bring liquor and / or drugs onto the property.
4. Residents may not enter the premises in a drunken/drugged state this could contribute to unruly behaviour and self-neglect.
5. Residents may not bring friends/family/ children into the bedrooms.
6. Visitors may not extend their visitation to a daily basis and/or spend the whole day on the premises unless discussed with Management.
7. Residents may not allow friends/family to sleep over on the premises.
8. Residents may not debar fellow residents from any section of dwelling.
9. No residents may utilise the kitchen, lounge or ablution area as their Sole proprietary ownership.
10. Designated areas are to be utilised for the functions indicated only, e.g. Cooking (kitchen) ablution(bathroom) relaxing(lounge) resting/sleeping (bedroom).
11. Activities which promote rehabilitation/development must be practised In designated areas in consultation with all within the living unit.
12. Activities which provoke and/or disturb others must be reported to Management.
13. The limited privacy of each resident is to be respected by all.
14. Smoking is not allowed in the bedrooms. Designated areas must be used.
15. Residents must declare all income to Management.
16. Residents must declare all new clothing items, bedding or any other items in order for the Kit list to be updated and marked.
17. Residents should not use physical and /or psychological abuse on one another.

18. Residents may not subject one another to bullying tactics, slandering and gross defamatory accusations.
19. Residents may not steal – or encourage the same- from one another.
20. Residents who become ill / frail will be referred the CHC / Hospital or relevant Doctor.
21. In the above regard residents must refrain from false representation and injurious diagnoses of fellow residents. This must be done by qualified experts upon request as non-adherence may lead to serious violations of person's rights, dignity and privacy.
22. In contrast to the above residents must report in any incidence of obviously ill, unwell and inappropriate behaviour (take note symptoms) to the management.
23. Residents must not discriminate against one another on the grounds
    - race, gender, sex, ethnic / social origin, colour,
24. Sexual orientation, age, disability, religion, believe, culture or language amongst other. Thus, no discrimination will be allowed on the grounds of educational standard, physical appearance, colour, illness, religious and other beliefs, disabilities, language and culture.
25. Residents may not deliberately cause any damages to the structures and equipment of the Organisation.
26. Electricity and water must be used sparingly.
27. Residents may not subject staff or one another to unwarranted sexual harassment.

OUR AGED • ONS BEJAARDES
THE KENSINGTON HOME FOR THE AGED

New Admission Check List

This form must be completed by the resident or the person responsible for the resident.
Record all Clothing & Non-Clothing Items

Resident: ____

Item (Dress, Trousers etc)	**Qty**	**Description** (Colour/Make)	**Checked**		
			YES	NO	OUT

Date: ________________ Received/Checked/Marked By:_____________________________

Re-Marked By:____

____

Checked Out By: ________________________ Date: _______________________

Updated: 01/2021

THE KENSINGTON
HOME FOR THE AGED

KENSINGTON HOME FOR THE AGED

SOCIAL WORKER REPORT FOR ADMISSION INTO THE HOME
MAATSKAPLIKEWERKER SE VERSLAG VIR TOELATING TOT DIE TUISTE

- Please send direct to the Home an attached a supplementary report.
  Stuur asb direk aan die tehuis en voeg n aanvullende verslag by indien nodig
- Complete the point scale of the Social Services)
  Voltooi as ook die punteskaal van die betrokke Staatsdepartement

FULLE AND SURNAME: --
VOLLE NAAME EN VAN:

ADRESS: ---
ADDRES:
----

1. Family composition: ---
   Gesinsamestelling:
   ----

2. Family relationship: --
   Gesinsverhouding:
   ----

3. Personal details: ---
   Persoonlike besonderhede:
   ----

4. Surroundings and housing circumstances: (standard of life, reason for applying, motivation, urgency)
   Omgewing en behuisings omstandighede: (lewensstandaard, rede vir versoek, motivering, dringendheid)

   ----

5. Psychical state: (complete point scale) ---
   Psigiese toestand: (voltooi punteskaal)

   ----

6. Physical condition: (complete point scale) ---
   Fisiese toestand: (voltooi puntestaat

   ----

7. Financial position: --
   Finansiele omstandighede:
   ----

8. Recommendations: ---
   Aanbeveling:
   ----

9. Herewith I declare that the information given on this application form is complete to the best of my knowledge, I undertake that in case I will be taken in as a resident of the Home, I will abide by the rules and regulations of the Home.
   Hiermee verklaar ek dat die gegewens op hierdie aansoekvorm verstrek na die beste van my wete waar en juis is. Ek onderneem om, indien ek as inwoner van die Tehuis opgeneem word, my neer te le by the reels en regulasies van die Tehuis.

Signature of applicant: --
Handtekening van applikant:

Signature of Witness: -- Date: --
Handtekening van getuie:

Where do you live? ---
Waar woon u tans?

When do you want to be admitted? Later---------------------------- As soon as possible ---------------------------------
Waaneer will jy opgeneem word? So gou as moontlik

Social worker ---

Address---

Telephone/Telefoon --

Signature: -- Stamp:

Date:----------------------------