

STRICTLY PRIVATE AND CONFIDENTIAL

Life Right

Rental

APPLICATION FORM FOR ADMISSION TO: Option 1

Option 2

Option 3

- Please note:**
- (a) All applicants are to complete the form in full
 - (b) Married couples need complete separate forms
 - (c) Ensure that all attached documents are completed and signed
 - (d) Admission is subject to suitability by need, specific criteria and approval by a Selection Committee
 - (e) Ensure that you read and understand Annexure "A" of this form
 - (f) Completed CPOA medical report will be required by a registered doctor
 - (g) Debt order form is compulsory to complete in this application
 - (h) Copy of ID must be included

1. Full Name:			
2. Present Address:			
Postal Code:			
3. Telephone No:		Cell Phone No:	
4. E-mail address:			
5. Identity No (copy attached):			
6. Nationality:			
7. Date of Birth:			
8. Marital Status:			
8.1 If married, state name of spouse:			
8.2. Date and Place of Marriage:			
9. Home Language:			
10. Religion:			
11. (a) What was your occupation or profession?			
(b) What is or was your husband's\wife's occupation or profession?			
12. Details of children:			
Name	Age	Address	Present Occupation
13. Name\Address\Tel. No. of next of kin or contact Person:			
14. State briefly the reason why you are seeking admission to this complex:			
15. Type of accommodation applied for:			
16. When do you require accommodation:			
17. Name\address\telephone number of your doctor to be contacted in an emergency:			
19. Medical Aid Scheme and number:			
20. Which funeral parlour would you wish Management to contact:			
21. Income Tax No.			

DEED OF SURETYSHIP

I / We the undermentioned / undersigned

SURNAME: _____ FORENAMES: _____

I.D. NO.: _____

RESIDENTIAL ADDRESS: _____ CODE _____

POSTAL ADDRESS: _____ CODE _____

TEL: (home) _____ (work) _____ (cell) _____ E-MAIL: _____

OCCUPATION / PROFESSION: _____

EMPLOYER'S NAME & ADDRESS: _____ CODE _____

E-MAIL _____ FAX _____ TEL _____

Should you be married in Community of Property, please complete section below.

SPOUSE SURNAME: _____ FORENAMES: _____

I.D. NO.: _____

WORK ADDRESS: _____ CODE _____

CELL: _____ E-MAIL _____

Please provide:

1. Proof of residency, i.e. copy of telephone bill or rates statement
2. Copy of latest pay slip and bank statement.
3. Statement of assets – fixed deposits, house, car and liabilities.

I do hereby guarantee and bind myself / ourselves jointly, severally and in solidum to CPOA as Surety / Sureties in solidum for and co-principal/s with

RESIDENTS NAME & SURNAME: _____

RELATIONSHIP: _____ Home-Residence _____

for the due and punctual payment (by the 1st of each month) to CPOA of any amounts which debtor may now or in the future owe to CPOA in respect of board and lodging, or any other indebtedness (i.e. pocket money, room service, guest meals etc.). In the event that no payment is made, CPOA reserves the right to move or give notice to the resident and to hand the surety over to the Attorneys.

It is AGREED that this Suretyship shall remain in force as a continuing security notwithstanding any fluctuations in the amount due by the debtor (agreed amount is subject to an annual increase).

DATED AT _____ THIS _____ DAY OF _____ 20 _____

SURETY: _____ DATE: _____

SPOUSE: _____ DATE: _____

AS WITNESSES: 1. _____ 2. _____

ACKNOWLEDGEMENT OF DEBT

I....., do hereby acknowledge

- 1) my responsibility to ensure that any recurring or intermittent accounts are paid timeously and that failure in this regard will result in legal action being taken by CPOA to recover amounts owed.
- 2) the right of CPOA on my death to apply to my estate for payment of any amount which may be due to CPOA.

Dated at this the day of 20.....

Signature of Debt Holder

AS WITNESSES:

1. _____

2. _____

MEDICAL ASSESMENT IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO AN ECONOMIC CARE CENTRE

(To be completed by a Medical Practitioner)

Care Centre _____

1. SURNAME OF APPLICANT: _____ FIRST NAME(S): _____

2. APPLICANT'S COMPLAINTS (HISTORY, SYMPTOMS & PREVIOUS TREATMENT)

Medical: _____

Surgical: _____

Psychiatric: _____

3. GENERAL EXAMINATIONS:

General physical and nutritional state

Temperature:	Weight:	Pulse:
HB:	BP:	Urine Test Results:

Any abnormalities of	YES	NO	Comment
Respiratory system			
Cardio-vascular system			
Gastro-intestinal system			
Endocrine system			
Ear, nose and throat			
Central nervous system			
Tremors			
Parkinson's			
Multiple Sclerosis			
Motor Neurone disease			
Neuropsychiatric			
Other			



	YES	NO	Comment		
Muscular-skeletal system					
Osteoporosis					
Osteoarthritis					
Rheumatoid arthritis					
Locomotive disabilities					
Hemiplegia					
Myopathies					
Other					
Spectacles					
Contact lenses					
Implants					
Has the applicant any history of alcohol or drug dependency?					
Has the applicant any history of drug dependency?					
Smoker?					
Allergies					
Skin Diseases (include bedsores, ulcers ect.)					
Is the applicant incontinent?			Urine	Faeces	
Has the applicant any communicable disease/s?					
Current treatment					
Presence or suspicion of neoplasm, tumours?					
Treatment regime?					
Hearing	Good	Partially Deaf	Deaf		Hearing Aid
Does the applicant require assistance in:	respect of mobility	personal hygiene	dressing or undressing	medication	feeding
Mental conditions	Normal	Restlessness	Depression	Insomnia	Senile Dementia
	Anxiety	Abusive	Psychosis	Behaviour Disorder	Aggressive/ Violent



	YES	NO	Comments
Reasonable recall of recent events?			
Is applicant fully time-and-place orientated?			
Has the applicant any history of wandering from home?			
Mini Mental Score			

4. HOW LONG HAVE YOU BEEN IN ATTENDANCE ON APPLICANT? (IF FIRST VISIT, NAME OF USUAL MEDICAL DOCTOR.)

5. CURRENT MEDICATION:

6. GENERAL REMARKS:

Date: _____

Signature: _____

General Practitioner

ANNEXURE B

STATEMENT OF INCOME AND EXPENDITURE

NAME OF APPLICANT:

DATE:

SOURCE OF INCOME	AMOUNT
A) Type of Pension and number	
1.	
2.	
3.	
B) Spouses pension and number	
1.	
2.	
C) Other income (i.e. Annuity\Cash investments)	
1.	
2.	
3.	
D) Revenue from Property	
1.	
2.	
TOTAL INCOME:	
EXPENDITURE	
1. Medical Aid	
2. Burial Insurance	
3. Other Expenditures (Not telephone, electricity or food)	
TOTAL:	
MONTHLY INCOME:	

Account No:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Branch:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Signature of applicant or delegated person:

DEBIT ORDER INSTRUCTION FORM

Name of Bank: _____

Branch Name: _____

Branch Number:

--	--

--	--

--	--

--	--

Type of Account: Current (Cheque)\ Savings

Account No:

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I\We hereby request, "instruct" and authorise the Cape Peninsula Organisation for the Aged to draw against my\our account with the abovementioned bank (or any other bank or branch to which I\we may transfer my\our account) the amount necessary for payment of the monthly amount due in respect of Board and Lodging\Levies and additional sundry expenses (for example Meals, room service, garage rentals etc.) on the FIRST day of each and every month. All such withdrawals from my\our account by CPOA shall be treated as though they had been signed by me\us personally.

I\We understand that the withdrawals hereby authorised will be processed by computer through a system known as the ACB Magnetic Tape Service, and I\We also understand that details of each withdrawal will be printed on my\our bank statement or on an accompanying voucher.

I\We agree to pay any bank charges relating to this debit order instruction.

This authority may be cancelled by me\us by giving CPOA thirty days notice in writing, sent by prepaid registered post, but I\we understand that I\we shall not be entitled to any refund of amounts which CPOA has withdrawn while this authority was in force if such amounts were legally owing to CPOA.

Receipt of this instruction by CPOA shall be regarded as receipt thereof by my\our bank (whichever it is or will be).

ASSIGNMENT:

I\We acknowledge that the party hereby authorised to effect the drawing(s) against my\our account may not cede or assign any of its rights to any third party without my\our prior written consent and that I\we may not delegate any of my\our obligations in terms of this contract\authority to any third party without prior written consent of the authorised party.

Name: _____ Home\Residence _____ Ref. No. _____

Signed _____ on this _____ day of _____ 20

Signature as used for signing of cheques

Assisted by (where legally necessary)

Capacity

Note: A cancelled cheque must be attached for bank identification purposes (Current accounts only).

FINANCES

Please complete Annexure B and provide proof of financial status by attaching a verified statement of sufficient income to cover all liabilities.

Should you not have the above required income, please have a family member sign a Deed of Surety for the balance.

The payment of the monthly tariff should be by debit order. Please complete the enclosed debit order form.

Any change in your financial status affecting your ability to afford the minimum amounts required must be reported immediately to the Manager.

To ensure that your assets are placed under your Executors control, please supply the following information:

Where is your Will lodged? _____

Who are your Executors? _____ Tel No. _____

UNDERTAKING BY APPLICANT

- (a) I hereby declare that the information furnished by me is, to the best of my knowledge, true and correct.
- (b) My full medical history and financial status have, to the best of my knowledge and belief been completely disclosed.
- (c) I agree to abide by the requirements set out in Annexure A.

Signature of Applicant

Date

THIS FORM IS TO BE RETAINED BY THE APPLICANT AND / OR NEXT OF KIN

ANNEXURE "A"

UNDERTAKING BY APPLICANTS ADMITTED TO CPOA COMPLEXES

If I am admitted to a home/residence under control of the Cape Peninsula Organisation for the Aged, I hereby acknowledge/irrevocably agree:

Date: _____ Signature: _____ Relationship: _____

1. To abide by the Organisation's regulations and household rules and amendments thereto.
2. To pay my monthly board and lodging fees in advance on the first day of each month, the amount of which fees are calculated in accordance with the Organisation's board and lodging policy.
 - 2.1 Should it occur that there are board and lodging shortfalls due by me then, with the Organisation's written approval, these may be accumulated as a debt against my Estate.
 - 2.2 CPOA reserves the right to increase the Board and Lodging tariff on the 1st April each year.
 - 2.3 Any funds belonging to me and given by myself or on my authority to the Organisation to be held in Trust for me may, in the event of my death, be applied towards settling my debts that I may have incurred with the Organisation.
 - 2.4 I/we understand that together with my/our relatives, funeral arrangements and costs are our responsibility. If a funeral policy exists that is not paid-up, we accept that the payment of these monthly premiums must be undertaken by the resident's and/or relatives.
3. Where medical, nursing and paramedical services are not included in the board and lodging tariff of the complex, the resident will be charged for such services.
 - 3.1 In the event of my being admitted to a CPOA complex that does not have a nursing staff complement, I accept that should health problems necessitate the administration of medication that I am prepared to accept this procedure from other staff members.
4. As a permanent resident should I decide to leave the complex, I will give the Organisation two calendar months' notice in writing, or pay the Organisation two months' board and lodging in lieu of notice. Should I pass away while resident in the CPOA complex, an administration fee equivalent to one month's full board and lodging will become payable from my Estate.
 - 4.1 CPOA reserves the right to grant access to the next of kin involved in the admission process.
 - 4.2 The next of kin involved in the admission process has the right to declare who may, may not visit or remove the resident from CPOA's property. This is subject upon CPOA investigation between the resident and next of kin.
5. The SELLER shall at all times retain the right, in the event of the mental or physical disability of either the PURCHASER or his or her spouse, deteriorating to such an extent that the SELLER'S care in the Unit is inadequate, to cause such a PURCHASER in consultation with their family and Medical Practitioner to be moved from the Unit to the health care facility or to another complex administered by the SELLER where such adequate health care can be provided. CPOA has the right to temporarily place a resident in a suitable unit to protect themselves and other residents, whilst process to permanently place them is in motion.
6. That the Organisation does not accept responsibility for any personal possessions, jewellery, documents, appliances, etc. brought into the complex by me and that I am responsible for the insurance of such items.
7. That should I require a wheelchair, I will purchase or hire same and maintain it in good condition at my expense.
8. CPOA reserves the right to refer residents for assessment by medical professionals.
9. That should the need arise for any emergency operation to me and my next-of-kin is not available, the manager of the complex or his/her nominee may furnish the consent required by the medical authorities.
10. CPOA reserves the right to give notice to residents who exhibit anti-social behaviour, with the care of the resident becoming the relative's responsibility.
11. CPOA is not responsible for Medical Aid claims. This is the responsibility of the family.

OFFER TO PURCHASE

NAME OF SCHEME:

UNIT NO.:

I hereby offer to purchase above unit at the listed price of R.....

I also agree to pay 10% deposit within 7 (seven) days after signing the life right document (based on listed price).

Balance of Listed price will be paid

Cost of upgrade to be paid on date of occupation.

Levy excluding service (e.g. meals) is payable after signing this document, if not occupied.

After occupation full levies are payable.

This document forms part of the Life Right Agreement.

DETAILS OF PURCHASER (S) OF LIFE RIGHT	
SURNAME / NAME	
FULL NAME (S)	
IDENTITY NUMBER	
HOME TEL NO.	
WORK TEL NO.	
CELL NO.	
EMAIL ADDRESS	
INCOME TAX NO.	
PREFERRED CONTACT NO.	
MARITAL STATUS	
DATE & PLACE OF MARRIAGE	
SPOUSE (second occupant) FULL NAMES	
IDENTITY NUMBER	
SPOUSE CELL NUMBER	
PHYSICAL ADDRESS	
POSTAL ADDRESS	
INCOME TAX NO.	

THUS SIGNED on behalf of the PURCHASER at _____

On the _____ day of _____ 20_____

PURCHASER

AUTHORISED CPOA REPRESENTATIVE