St Francis CARE CENTRE
Dedicated to comfort, care & compassion
APCC ASSOCIATION OF PALLIATIVE CARE CENTRES
VALIDATED ORGANIZATION CAF GROUP
011-894-4151
secretary@stfranciscarecentre.co.za
30 Olivia Rd, Eveleigh, Boksburg, 1459
Registration No: 011-441 NPO / Practise No: 079 0000470546 / VAT No: 4490178623 / PBO No: 18/11/13/3746

APPLICATION FOR PALLIATIVE CARE ADMISSION

Please complete all applicable fields in full. Supporting medical and admission documentation must accompany this application.

1.PATIENT DETAILS

Admission Date: _____
First Names: _____
Surname: _____
ID / Passport Number: _____
Cell Phone Number: _____ Alternative Contact: _____
Date of Birth: _____ Age: _____
Gender: _____ Marital Status: _____
Home Address: _____
_____
Place of Birth: _____ Occupation: _____
Smoker: YES / NO _____ Alcohol Use: YES / NO _____
Social / Substance-Related Concerns: YES / NO _____
Highest Education Level: _____ Religion: _____
Baptised: YES / NO _____

2. PERSON RESPONSIBLE FOR ACCOUNT

This person will be the primary contact for account, payment and administrative matters.

First Names: _____
Surname: _____
ID / Passport Number: _____
Cell Phone Number: _____ Alternative Contact: _____
Date of Birth: _____ Age: _____
Gender: _____ Relationship to Patient: _____
Residential Address: _____
_____
Postal Address: _____
_____
Occupation: _____ Employer / Company: _____
Email Address: _____
Medical Aid / Fund: _____ Membership Number: _____
Responsible for Payment: YES / NO _____ Section 18A Certificate Requested: YES / NO _____

3. FAMILY AND NEXT OF KIN

Dependent Children (Names & Ages): _____
If applicable, left in whose care: _____
Next of Kin: _____ Relationship to Patient: _____
Next of Kin Contact Number: _____
Next of Kin Address: _____
_____
SASSA Grant: YES / NO _____ If NO, Applied: YES / NO _____
If discharged, who will collect the patient?: _____

Other Relevant Information: _____

4. REFERRAL AND CLINICAL INFORMATION

Patient Referred By: _____
Referring Doctor / Healthcare Professional: _____
Primary Diagnosis / Reason for Referral:
_____
Current Medical / Palliative Care Needs:
_____
Relevant Medical History / Additional Information:
_____
Admitting Officer / Professional Nurse: _____
Date of Assessment: _____ Time: _____

5. ADDITIONAL CONTACTS (NOT RESIDING WITH THE PATIENT)

ADDITIONAL CONTACT 1
Name: _____ Relationship: _____
Contact Number: _____
Address: _____
Email Address: _____

ADDITIONAL CONTACT 2
Name: _____ Relationship: _____
Contact Number: _____
Address: _____
Email Address: _____

6. FEES AND PAYMENT TERMS

• Admission Fee: R500.00 (once-off).
• Monthly Fee: R7,500.00 for a 30-day month / R7,750.00 for a 31-day month.
• On admission, the full monthly fee is not charged. A daily rate of R250.00 applies for the remaining days of the month, and this amount is payable in full.
• All applicable fees are payable in accordance with the Centre's current payment arrangements. The person responsible for the account remains responsible for any outstanding balance.
IMPORTANT: The completed application must be submitted together with a medical report and an acceptance letter obtained prior to the patient's arrival.

REFUND POLICY: There are no refunds for amounts paid, subject to any rights or obligations required by applicable law or expressly agreed to in writing by the Centre.

7. TERMS AND CONDITIONS

1. Admission is subject to assessment, availability of an appropriate bed, and formal acceptance by St Francis Care Centre.
2. The application must be completed accurately and honestly. The Centre must be informed promptly of any material change in the patient's medical, personal, contact or financial circumstances.
3. A current medical report and the required acceptance documentation must be provided before admission. Additional information may be requested where reasonably necessary to assess and provide appropriate palliative care.
4. The patient and/or person responsible for the account accepts responsibility for accurate information and for payment of all applicable fees and charges in accordance with the Centre's current fee schedule.

PAYMENTS ARE DUE ON THE 1ST OF EVERY MONTH

5. Fees and payment arrangements may be amended from time to time. Where applicable, the responsible person will be informed of changes.
6. All amounts paid are non-refundable, except where the Centre is legally required to provide a refund or expressly agrees otherwise in writing.
7. Admission does not guarantee a specific room, bed, staff member or length of stay. Care arrangements may be adjusted according to the patient's needs and the Centre's operational requirements.
8. Where a patient is discharged, the responsible person or nominated collector is responsible for making appropriate collection and transport arrangements as agreed with the Centre.
9. The patient and/or responsible person authorises the Centre, where reasonably necessary for admission, care, administration, billing or discharge, to communicate with nominated contacts, the referring healthcare professional, medical aid provider and other authorised parties, subject to applicable confidentiality and privacy requirements.
10. Concerns regarding care, accounts or administration should be raised with the Centre as soon as reasonably possible so that they may be addressed.
11. By signing this form, the patient and/or responsible person confirms that the information supplied is accurate, that the terms and conditions have been read and understood, and that the applicable admission and payment requirements are accepted.

8. DECLARATION, CONSENT AND SIGNATURES

I/we declare that the information provided in this application is true and complete to the best of my/our knowledge. I/we understand the admission, care, fee and payment requirements and agree to comply with the applicable terms and conditions of St Francis Care Centre.

Responsible Person Full Name: _____
Signature: _____ **Date:** _____
Relationship to Patient: _____ **Contact Number:** _____
Witness Full Name: _____
Contact Number: _____
Witness Signature: _____ **Date:** _____