Pietermaritzburg
Mental Health

Dear Sir / Madam

RE : APPLICATION FOR ADMISSION

Thank you for your enquiry concerning Admission to our Residential Facilities and/or Protective Workshops.

Please have all these forms completed and returned to the Social Worker concerned. Please include a certified copy of the following:

- ID Book of Mental Health Care User.
- 2 recent colour ID photos of Mental Health Care User
- Copy of smart card of Mental Health Care User

An application fee of **R150-00** is payable on returning the forms. **(This deposit is non-refundable)** Please note that your Application cannot be processed before ALL the forms are completed and the fee is paid. The Application will be screened by the Admissions Committee. Your Application will be treated with utmost **confidentiality.**

Thank you for your co-operation.

Yours faithfully

SOCIAL WORKER **DATE**

PO Box 133, Pietermaritzburg 3200 | 133 Jabu Ndlovu Street, Pietermaritzburg 3201
Tel: +27 (0)33 392 7230 | Email: pmbmhs@xsinet.co.za | www.pmbmhs.org.za
Constituent body of SA Federation for Mental Health | Member of Community Chest | 002 272 NPO | PBO 130001452

PIETERMARITZBURG MENTAL HEALTH

CHECK LIST FOR ADMISSION PACK

Forms for applicant to complete

FORM NUMBER IN PACK ORDER	COMPLETED FORMS RETURNED AND CHECKED ✓x	TITLE OF FORMS IN ORDER
	N/A	COVERING LETTER TO CONCERNED PERSON
FORM 1		FEE STRUCTURE
FORM 2		**APPLICATION FOR ADMISSION**
FORM 3		MEDICAL REPORTS
FORM 4		INDEMNITY FORM
FORM 5		GENERAL RULES AND REGULATIONS
FORM 6		**REFERRING** SOCIAL WORKER'S REPORT

Forms for social worker to complete

		SOCIAL WORKER'S PSYCHO SOCIAL REPORT
FORM 7		ADMISSION FORM FOR CENTRAL OFFICE GRANT ADMINISTRATION **(X 3 COPIES)**
FORM 8		MONTHLY CONTRIBUTION FOR FEES **(X 3 COPIES)**
FORM 9		CLIENT DETAILS **(x 2 COPIES)**
		DQ.98 DEPENDENCY QUESTIONNAIRE (FRAIL ASSESSMENT)
FORM 10		DEGREE OF DISABILITY
FORM 11		WORKPLACE SKILLS ASSESSMENT
Checklist done by:	**Social worker:**	**SIGNED:**
COPIES BACK TO FAMILY	**YES /NO**	**SIGNED:**

Completed admission pack and file to be presented to Admissions committee.

FORM 1

PIETERMARITZBURG MENTAL HEALTH

FEE STRUCTURE WITH EFFECT FROM 1 APRIL 2021

RESIDENTIAL FEES **(includes workshop fees)**

A. DISABILITY GRANT RECIPIENTS R2 516.30 PER MONTH

Disability Grants are to be transferred to our Composite Voucher after three months probation period is complete. (This is not negotiable.)

B. PRIVATE: R6 170.00 PER MONTH
(e.g. Non – Grant Recipients)

WORKSHOP FEES (Community MHCUs)

A. DISABILITY GRANT RECIPIENTS R1 170.00 PER ANNUM
Payable in advance

PLEASE NOTE:
Fees are payable in advance – not later than the 7th of the month.
Non-payment of Fees will result in the MHCU being given notice to leave It should be noted that as per South African law, family members are responsible for each other.

In the event that there are immediate family members, they will be expected to contribute to any shortfall in fees payable, (immediate family members comprise children, parents and brother and sisters).
The ***applicant*** is regarded as the designated family member, who will be responsible for shortfall funding etc. it will also be this family member who will act and make decisions on behalf of the mental health care user, where appropriate. PMBMHS will not deal or interact with a variety of family members. In the event of outstanding debt it will be this person who will be held responsible.

PLEASE INDICATE WITH A TICK WHICH METHOD OF PAYMENT OF FEES THAT WILL BE USED

TERMS :	**YES:**
1. In cash to Central Office	
2. Direct deposit in PMB Mental Health Bank Account, and photocopy of deposit slip to MHS	
3. Debit order into PMB Mental Health Bank Account.	
4. Electronic Banking.	

PERSON RESPONSIBLE FOR PAYMENT

APPLICANT'S NAME:_____
Print

SIGNATURE:_____ **DATE:**_____

***NB: Please ensure a copy of this goes back to the person who signs this.**

FORM 2

PIETERMARITZBURG MENTAL HEALTH

APPLICATION FORM

APPLICATION IS FOR WHICH SERVICE?	INDICATE √
PROTECTIVE WORKSHOP	
RESIDENTIAL FACILITY (includes workshop)	

IDENTIFYING DETAILS OF **PERSON REQUIRING SERVICE:**	
SURNAME: (According to ID Book)	
CHRISTIAN NAME/S : (According to ID Book)	
ALSO KNOWN AS:	
IDENTITY NUMBER:	
DATE OF BIRTH :	
MARITAL STATUS :	
NUMBER OF CHILDREN:	
LANGUAGE :	
RELIGION :	
NAME OF APPLICANT	
RELATIONSHIP TO PERSON REQUIRING SERVICE	
PERMANENT ADDRESS : (Physical)	
POSTAL ADDRESS : (For Account Purposes)	
TELEPHONE NUMBERS :	

INVOLVED FAMILY

NAME	ADDRESS	RELATION-SHIP	TELEPHONE WORK	TELEPHONE HOME	CELL

FINANCIAL STATUS OF PERSON REQUIRING SERVICE :		
1. Is he/she in receipt of State Grant ? :	YES	NO
2. Is there a Smart Card ? :	YES	NO
3. Where is the Grant drawn ? : How is it paid ?		
4. If he/she has dependents , are there financial commitments ?		
5. Is he/she in receipt of any **TRUST** monies ?: (Detail)		
6. Does he/she have and Insurance on his/her life? If so, give full details :		
7. Does the he/she have a Funeral Policy ? If so, give full details		
8. Does the he/she have a Will ? If so, give details and where it is kept		
9. If there is no Will , is assistance required in drawing up a Will?		
.EDUCATIONAL AND OCCUPATIONAL STATUS		
1. Name of last school attended :		
2. Highest Standard/Grade passed in school Year completed		
3. I Q Score ? : (if available)		
4. Training after school:		
5. Work experience (including previous workshops attended)		

MEDICAL CARE AND EMERGENCY CONSENT

OPTIONS	INSTRUCTION:		TICK CHOSEN OPTION ✓
OPTION 1	Receive medical and dental care at a relevant provincial hospital / or clinic.		
OPTION 2	Receive medical and dental care at a private doctor namely		
Name of Doctor		Medical Aid Plan	
Tel.No.		Medical Aid No	
Address of Dr.		Name Of Principal Member	
Name of Dentist		Tel.No of Dentist	
Address of Dentist			
OPTION 3	I / We will be responsible for all medical payments and claims and PMB MENTAL HEALTH will not be held responsible for any accounts of this nature.		
OPTION 4	In the event of and emergency I / We give permission to the PMB MENTAL HEALTH to call upon any medical practioner or service they deem necessary.		
OPTION 5	**BIRTH CONTROL CONSENT** MHCU to be placed on a method of Birth Control which is suitable for her , **PRIOR** to admission		
OPTION 6	The applicant has had one of the following **SURGICAL PROCEDURES**		
		Yes /no	Date
	Tubal Ligation		
	Hysterectomy		
	Vasectomy		

SWORN STATEMENT BY APPLICANT

I _____ under-signed **APPLICANT** on behalf of the

PERSON REQUIRING SERVICES _____. hereby undertake to comply with the following: **(MHCU)**

- The Rules of the Protective Workshop and Residential Facilities .
- To ensure that the payment of all fees are to be paid strictly in advance, as laid down by the Board of Management.
- To accept the condition that the Person Requiring Services/ Mental Health Care User (**MHCU**) will be admitted on a probationary period of three(3)months, thereafter, to accept the **MHCU** permanently to the Centre, or will inform me to receive the **MHCU** back into my care . I further understand that the Executive Director is not obliged to give any reason for the non-acceptance of the **MHCU**'s placement. I then undertake to make alternative arrangements for the **MHCU**'s future accommodation.
- Provide one (1) calendar months' notice . In the event of leaving ,
- Take full responsibility for all funeral arrangements and the cost thereof. In the event of the death of the **MHCU**.
- Inform the Society of any change in my address and / or telephone number.
- I give permission to the PMBMH's Social Worker to share / receive confidential information concerning the **MHCU's** past and present circumstances with / from other health professionals and / or lay persons involved in the care, given that such information in the opinion of the Social Worker is deemed necessary.
- I give permission for any photographs of the **MHCU** to be used and published in the PMBMH's promotional working any media.

1. FULL NAME OF APPLICANT (block letters)
RELATIONSHIP TO PERSON REQUIRING SERVICES
TELEPHONE NO: (H) (W)
ADDRESS
2. FULL NAME OF ALTERNATE RESPONSIBLE FAMILY MEMBER :
RELATIONSHIP TO PERSON REQUIRING SERVICES:
TELEPHONE NO: (H) (W) .
ADDRESS:
NAME OF LAW FIRM AND COMPANY IF APPLICABLE
I declare that the information provided concerning this application is true and correct. I have received, read and understood the contents of the application for admission pack
_____ _____ **APPLICANT SIGNATURE** **DATE**
_____ _____ **SIGNATURE ALTERNATE RESPONSIBLE FAMILY MEMBER** **DATE**

INFORMATION ON FINANCES OF APPLICANT

EMPLOYMENT INFORMATION OF PERSON RESONSIBLE FOR FEES (APPLICANT)		
Occupation		
Place of employment/ Company		
Business address		
Telephone number		Cell number
Email address		

INCOME AND EXPENDITURE STATEMENT	R
INCOME:	
Gross Salary	
Nett Salary	
Pension	
Interest Investments	
Rent/Board & Lodging	
Other	
TOTAL INCOME	

EXPENSES:	R		R
Rent/Bond Repayments		Food	
Rates/Water/Electricity		Clothing	
Car Instalment		School Fees	
Loan Repayment		Funeral	
Higher Purchase Accounts		Other	
Insurance			
TOTAL EXPENDITURE			R

THIS APPLICATION FORM MUST/TO BE SIGNED BY A COMMISSIONER OF OATHS

PLEASE ATTACH CERTIFIED COPIES OF :-

- PAYSLIPS,
- BANK STATEMENTS FOR THE LAST 3 MONTHS
- ALL OTHER DOCUMENTS REQUIRED AS PROOF OF ALL INCOME & EXPENDITURE STATED ON THIS FORM.

INCOME DECLARATION

I _____ HEREBY CONFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

(Print Name)

_____ _____

SIGNED **DATE**

CERTIFIED BY COMISSIONER OF OATHS/ JUSTICE OF THE PEACE:

I certify that the deponent has acknowledged that he/she knows and understands the contents of the declaration, which was sworn to/affirmed by me and the deponents signature/ print was placed thereon in my presence.

OFFICIAL STAMP

_____

COMISSIONER OF OATHS/ JUSTICE OF THE PEACE:

_____

DESIGNATION (RANK)

PLACE: _____ **DATE:** _____

PERSONAL REQUIREMENTS ON ADMISSION (RESIDENTIAL)
Please detach and keep for admission

Please ensure that the resident has the following items on admission if accepted.

1. All personal items and clothing to be marked with the residents name.
2. Supply of one month's medication if on treatment for any physical or psychiatric condition.
3. Toiletries (bath soap, toothpaste, toothbrush, deodorant, body lotion etc)
4. Own linen. Duvet, towel, pillow etc. Can be negotiated
5. Cleaning items including: Bucket. 1 Box Soap powder Wash basket Pegs
6. Hangers
7. A small padlock and key for the cupboard
8. Referral letter from previous clinic attended
9. Family Planning Card
10. Clinic and Hospital Appointment Card
11. Identity Document plus x2 recent passport size colour photographs of MHCU
12. Smart Card

FORM 3

PIETERMARITZBURG MENTAL HEALTH

MEDICAL CERTIFICATE

IN RESPECT OF APPLICATION TO PROTECTIVE WORKSHOP OR RESIDENTIAL FACILITY

PAGE 1 to be completed by applicant and bring to doctor **PAGE 2 To be completed by your family doctor**

FULL NAME OF PERSON REQUIRING ADMISSION :		
MEDICAL HISTORY		
A. MENTAL DISABILITY AND BEHAVIOUR:		
1. Diagnosis : Age when diagnosed		
2. Details of present Medication		
3. Describe symptoms present when relapsed :		
4. In the past 5 years , how many relapses resulting in hospital admissions have there been ?		
5. Has he/she shown any of the following behaviours in the past?	**YES**	**NO**
• alcohol / substance abuse/smoker?		
• aggressive /destructive behaviour ?		
• sexually inappropriate behaviour ?		
• suicide attempts ?		
• theft / manipulation /swearing ?		
6. Has he/she a record of criminal offences?		
7. List previous care institutions he/she has been in:		
8. Please include any other relevant information regarding his/her psychiatric history :		

B. PHYSICAL:	**YES**	**NO**
1. List any Major illness / operations / accidents? and include dates		
2. Is he/she under treatment for a physical complaint? : (Specify medications)		
3. Can he/she bath / clothe / feed himself unaided?		
4. Is there a history or present problem with incontinence / bed wetting?)		
5. Any physical disabilities? (Detail)		
6. Is he/she on **birth control or has had tubal ligation / hysterectomy / vasectomy?** Please detail and give dates		
7. Date of last visit to Dentist :		
8. Please detail any Dietary considerations :		
9. Please detail any allergies :		

1. **GENERAL EXAMINATION : To be completed by family doctor**

   a. General Physical and Nutritional state : _____

   b. Respiratory System : _____

   c. Blood Pressure : (to be taken in all cases) _____

   d. Genito-Urinary System : (urine to be tested in all cases . Please indicate whether there has been any treatment for STD)_____

   e. Digestive and other Abdominal Systems : _____

   f. Weight_____

   g. Muscular and Skeletal System : (state defects)_____

   h. Central Nervous System : _____

   i. Epilepsy : (State particular type, severity and frequency of attacks and response to treatment) _____

   j. Eye, Nose, Ear and Throat disorder (eg: defective vision, recurrent tonsillitis etc) _____
   _____

   k. Is Applicant free from infections and contagious diseases ?_____

   l. Any other condition not included in the classification ?: _____

2. Please provide/confirm a diagnosis for the mental and/or physical disability of the applicant?
   _____

3. Can Applicant be satisfactorily cared for by an unqualified care giver? : _____

4. Will further Medical / Surgical treatment improve or cure the disabilities above? (If so, state clearly what treatment is recommended)_____

5. State present Medication: _____

6. General remarks:_____

7. How well known is patient to you ? _____

NAME OF MEDICAL PRACTIONER [PRINT]	SIGNATURE	DATE

PRACTICE NUMBER:_____ **TEL.NO**_____

FORM 4

PIETERMARITZBURG MENTAL HEALTH

INDEMNITY FORM

I, _____**(applicant's name)** responsible for

_____**(name of MHCU)**, and in consideration for him/her having been admitted to the PMB Mental Health facilities , do hereby Indemnify and hold harmless , PIETERMARITZBURG MENTAL HEALTH , and all staff and volunteers of the said facilities, against all, and any loss or damage which I , or the Mental Health care User **(MHCH)** shall , or may incur , or suffer arising out of the presence at , or the attendance of the service user at the protective workshop and residential facilities , and whether such loss or damage shall have been occasioned by the negligence of the aforesaid institution, committee, staff, volunteers, or otherwise .

PIETERMARITZBURG MENTAL HEALTH will endeavour to ensure the safety of the **MHCU** at all times.

This Indemnity shall be enforced against me in respect of loss or damage , arising out of the injury and / or death of the **MHCU** in the following:

- During transportation to and from the facilities.
- At the facilities.
- During visits and excursions arranged from the facilities.
- During sports, games and exercises, or any other activity organised at or on behalf of the facilities.

NAME OF APPLICANT : _____

SIGNATURE :_____ **DATE:**_____

ADDRESS: _____

TELEPHONE CONTACT NUMBERS :_____**(H)** _____**(W)**

_____**(C)**

AS WITNESS :

1. _____ DATE:_____

2. _____ DATE:_____

FORM 5

PIETERMARITZBURG MENTAL HEALTH

RULES AND REGULATIONS
FOR RESIDENTIAL FACILITIES AND PROTECTIVE WORKSHOPS

1. DUTIES:	All MHCUs are expected to participate in various duties in any facility. These tasks will be allocated by staff on a roster
2. DRESS CODE:	• MHCUs are to be appropriately dressed and neat **at all times.** • Male residents are required to shave daily. Beards must be kept neat and tidy at all times.
3. VISITORS:	• **ALL VISITORS TO REPORT TO THE STAFF ON DUTY.** • **NO VISITORS PERMITTED DURING WORK TIMES AT WORKSHOP** • **VISITORS MAY NOT :** Bring fire arms onto the property / take photographs without official permission/ be under the influence of drugs /alcohol • Any family member picking MUCUs up must always report to staff when fetching in work hours or at residences • No smoking permitted in any of the buildings, only at designated areas • **VISITING HOURS RESIDENTIAL FACILITIES:** Residents are encouraged to have friends and family on. **Saturdays & Sundays 2.00 – 4.00 p.m.** Visitors are to be entertained in the Lounge, Dining room or outside, but not in bedrooms. No visitors may sleep overnight, or have any meals or food from the facility. • **Visitors should not give food, clothes, money or cigarettes etc without consulting staff first.**
4. WORKSHOP ATTENDANCE	• All ***Residents*** are to attend the workshop daily, attendance is compulsory • **Hours of Work: from 07h30 to 15h30 Mondays to Fridays** • ***Community* MHCUs** must produce proof of pension collection dates, hospital or clinic appointments, and/or sick notes from doctor. • MHCUs may not leave the workshop without staff permission and a written permission slip this also applies to seeing the social worker • Workshops close for a month during mid- Dec Jan
5. UNACCEPTABLE BEHAVIOUR:	**SUCH AS:** • **DRUG AND ALCOHOL ABUSE** Under no circumstances will use or abuse of substances such as alcohol and dagga be permitted on the premises. Being under the influence of such substances on the premises is also not permitted. • **UNAUTHORISED SMOKING** inside buildings and during work times • **DISORDERLY BEHAVIOUR / CONFLICTS:** involving any disrespect in any form, including verbal, physical and sexual (including cell phone pornography) abuse • **THEFT and/ or DAMAGE TO PROPERTY** shall be paid for by the responsible MHCU • **BUSINESS DEALS such as** selling, swopping or giving of clothing or other items within or outside of the facilities without the signed permission of family or staff. will result in **severe disciplinary action, which may result in prosecution or suspension or discharge at the discretion of the management team**
6. NOTICE:	One (1) calendars months' notice is required when leaving a facility. MHCUs may obviously leave with less notice, however they will then forfeit the balance of their monthly Fees.
7. LIABILITY:	The Mental Health Society will not be held responsible for lost property and/or money. Valuable articles should not come into the residential facility, or are kept at the owner's own risk.
8. GRATUITIES AND FEES	Gratuities and fees by MHCU or family to individual employees of PMBMH are prohibited

ON ADMISSION TO RESIDENTIAL CARE PLEASE NOTE FORM 5 cont

9. MEDICATION and MEDICAL CONSULTATIONS:	• All medication and over the counter medication must be entrusted to the Sister / Care Giver, Instructor. MHCUs may not manage own medications • Visits ***with family members*** to the Doctor, Clinic, Hospital or other must be discussed with the Care Giver at least 24 hours in advance. • Birth Control must be arranged prior to admission
10. CLOTHING:	All clothing including own linen must be marked with the residents name prior to admission. All subsequent purchases to be marked and handed to the staff.
11. CIGARETTES/ TUCK/ MONEY	All cigarettes, tuck and money must be handed **to the staff** No smoking permitted in any of the buildings, only at designated areas
12. HOLIDAYS:	Residents are free to go out for weekends/holidays on condition that : • The Social Worker is notified in advance. • Where the visit is to be longer than a weekend, then two weeks advance notice is necessary. • Suitable arrangements are made with Host / Hostess. • Board and Lodging fees will **NOT** be waived in the event of leave.
13. MEALS: **MEAL TIMES ARE AS FOLLOWS:**	• All are expected to be on time for all meals, which must be taken in the Dining room. • All Residents are to keep out of the kitchen, unless doing certain duties. • No meals are allowed in rooms unless permission given by Care Giver.

WEEKDAYS		**WEEKENDS**	
Breakfast	7.00 – 7.30am	Breakfast	8.00-8.30am
Lunch	12.00 – 12.30pm	Lunch	12.00-12.30pm
Supper	5.00 - 5.30pm	Supper	5.00 - 5.30pm

14. FURNITURE:	Residents are not allowed to put additional pieces of furniture in their rooms without the permission of the Principal, or to collect things that pile up in in their rooms. **Hoarding** will not be allowed.
15. APPLIANCES:	• No heaters, kettle, irons or fans are permitted. • Extension cords are discouraged. • Electrical appliances should be first cleared by the Manager or Principal
16. NOISE AFTER 10.00P.M:	**Radio and Television must be played softly, and switched off at 10.00p.m. Consideration and respect of others is expected of all Residents.**

ON ADMISSION TO PROTECTIVE WORKSHOPS PLEASE NOTE

17. REMUNERATION	Is based on productivity, attendance and behaviour and is not intended to be a salary
18. TEA/SMOKE BREAKS	• Breaks are specified. Eating drinking (including chewing gum) in the work time is not permitted. • No smoking permitted in any of the buildings, only at designated areas and times.
19. TUCK SHOPS	Only operate in breaks
20. CELL PHONES ELECTRONIC GAMES RADIOS AND EAR PHONES ETC	Are not permitted at the workshop at all.
21. COMMUNITY MHCU's MEDICATION and MEDICAL CONSULTATIONS	• All medication and over the counter medication must be entrusted to Manager if required during the day • Visits to the Doctor, Clinic, Hospital or other must be pre arranged with the manager • Birth Control must be arranged prior to admission

I , _____ agree to abide by the above conditions , and I understand that failure to follow these Rules may result in a discharge.

PRINT NAME

SIGNATURE OF APPLICANT **SIGNATURE OF MHCU** **DATE:**

***NB: Please ensure a signed copy of this goes back to Applicant**

FORM 6

REFERRING SOCIAL WORKER'S REPORT
FOR ADMISSION TO A PMB MENTAL HEALTH FACILITY

NAME OF ORGANISATION :	
ADDRESS:	**TEL:**
NAME OF SOCIAL WORKER : (Please Print Clearly)	

IDENTIFYING DETAILS:	
SURNAME:(According to ID Book)	
CHRISTIAN NAME/S :(According to ID Book)	
PERMANENT ADDRESS : (Physical)	
POSTAL ADDRESS : (For Account Purposes)	
TELEPHONE NUMBERS : Work:	
Home:	
Cell:	
DATE OF BIRTH :	
MARITAL STATUS :	
SEX:	
IDENTITY NUMBER :	
RELIGION :	
NAME OF FAMILY DOCTOR :	
TELEPHONE NUMBER OF DOCTOR:	
LANGUAGE :	

MEDICAL HISTORY :		
A. PSYCHIATRIC:		
1. Diagnosis :		
2. Details of present Medication		
3. Describe symptoms present when relapsed :		
4. In past 5 yrs , how many relapses resulting in hospital admissions have there been ?		
5. Which hospitals have been used?		
6. Did the client exhibit any of the following behaviours in the past?	YES	NO
• alcohol / substance abuse ?		
• destructive behaviour ?		
• sexually inappropriate behaviour ?		
• suicide attempts ?		
• aggressive behaviour ?		

7. List previous care institutions the client has been in and include dates and reasons for leaving:
8. Please include any other relevant information regarding clients psychiatric history :

B. PHYSICAL:
1. Major illness / operations / accidents ? : (Specify)
2. Can applicant bath / clothe / feed himself unaided ?
3. Is Client under treatment for a physical complaint ? : (Specify
4. Is there a history or present problem with incontinence / bed wetting ?)
5. Any physical disabilities ? (Detail)
6. Hospital Out-patient Department Number:
7. Is client on Birth Control ?
8. Please indicate date of last visit to Dentist :

:

C. EDUCATIONAL AND OCCUPATIONAL STATUS		
1. Name of last school :		
2. Standard/Grade passed in school	Year completed	
3. I Q Score ? : (if available)		
4. Training after school:		
5. Please detail any Work experience		

D. FINANCIAL STATUS :		
1. Employment information of parent/guardian		
2. Occupation of parent/ guardian		
3. Place of employment/ Company		
4. Business address		
5. Contact details		
6. Is Client in receipt of State Grant ? :	YES	NO
7. Is there a Smart Card ? :	YES	NO
8. Where is the Grant drawn ? :	How is it paid ?	
9. If client has dependents , are there financial commitments ?		
10. Is the client in receipt of any **TRUST** monies ?: (Detail)		
11. Does the Client have and Insurance on his/her life? If so, give full details :		

12. Does the Client have a Funeral Policy ? If so, give full details
13. Does the Client have a Will ? If so, give details and where it is kept
14. If there is no Will , would the client accept the assistance of MHS drawing up a Will?

E. BACKGROUND HISTORY :	
FATHER :	Date of Birth :
MOTHER :	Date of Birth :
SIBLINGS :	Date of Birth :
	Date of Birth :
	Date of Birth :
	Date of Birth :

NEXT OF KIN / INTERESTED PERSON/S WHO SHOULD BE CONTACTED IN AN EMERGENCY?

NAME	RELATIONSHIP	ADDRESS	TEL NO

F. DESCRIBE HOME CONDITIONS AND FAMILY RELATIONSHIPS

G. FINANCIAL SITUATION OF PARENT / GUARDIAN :
Gross income of parents/family:
Comment on situation :

H. SPECIAL CONSIDERATIONS
1(a) Behaviour problems : (mention Inter-personal relationships/independence & tendencies to wander / abscond)
(b) Please detail any recent substance abuse: (eg. alcohol /drugs)
(c) Please detail any recent aggressive , violent and destructive behaviour:
(d) Please detail any recent inappropriate / sexual behaviour : (eg. abuse / exhibitionism)
(e) Please detail past & present criminal offences:
2. Please detail any Dietary considerations ? :
3. Why does the Client require Home accommodation ? : If so, give reason for the Application :
4. What is the Client's attitude to the Protective Workshop and Home:
I . SOCIAL WORKER'S EVALUATION AND RECOMMENDATION:

SIGNATURE OF SOCIAL WORKER	**DATE**
OFFICIAL STAMP OF ORGANISATION :	

FORM 7

PIETERMARITZBURG MENTAL HEALTH

ADMISSION FORM
(For Office use Only)

RESIDENTIAL FACILITY
FULL CHRISTIAN NAME / S AND SURNAME : (IN BLOCK LETTERS)
OTHER NAME/S KNOWN BY:
DATE OF BIRTH :
IDENTITY NUMBER:
DATE OF ADMISSION:
PREVIOUS PLACE OF RESIDENCE :
PLACE WHERE DISABILITY GRANT IS DRAWN:
SOCIAL WORKER'S SIGNATURE _____ DATE _____

Instructions from Manager Residential Facilities :

Fees	R
Pocket Money	R
Funeral Policy	R
Ambulance Policy	R
Toiletry charge	R

_____ MANAGER RESIDENTIAL FACILITIES

_____ DATE

(Three copies) : 2 x Manager Residential Facilities
1 x File

FORM 8

PIETERMARITZBURG MENTAL HEALTH

MONTHLY CONTRIBUTION FOR RESIDENT'S
BOARD AND LODGING
(For Official use only)

NAME OF CLIENT :	
NAME OF RESIDENTIAL FACILITY:	
AMOUNT TO BE PAID IN:	
STATE METHOD OF PAYMENT:(Tick)	
1. Cash	
2. Deposit into Society's Account	
3. Debit Order	
4. Electronic payment	
NAME OF PERSON RESPONSIBLE:	
PAYER'S RELATIONSHIP TO CLIENT:	
DATE CLIENT ADMITTED TO HOME:	

Instructions To Manager Residential Facilities :

Fees	R
Pocket Money	R
Funeral Policy	R
Ambulance Policy	R
Toiletry charge	R

_____ SOCIAL WORKER

_____ DATE

(Three copies) : 2 x TO Manager Residential Facilities
1 x File

FORM 9

PIETERMARITZBURG MENTAL HEALTH

CLIENT DETAILS FOR RESIDENTIAL FACILITIES AND WORKSHOPS

(For Office use only)

SURNAME : _____ NAME:_____

DATE OF BIRTH: _____ I.D.:_____

ADDRESS:_____

FATHER'S NAME :	
MOTHER'S NAME :	
OTHER MEMBERS OF FAMILY : (BROTHERS / SISTERS)	

HOME TEL : **Home:**	EMERGENCY CONTACT TEL NO:
Work:	
Cell:	
EMERGENCY CONTACT ADDRESS:	
FAMILY DOCTOR TEL NUMBER :	
MEDICATION:	
ALLERGIES:	
EDUCATIONAL BACKGROUND:	
PREVIOUS EMPLOYMENT:	
MARITAL STATUS / FAMILY :	
ANY SPECIAL PROBLEM/S:	
SPORTING INTEREST:	
SOCIAL WORKER :	DATE ADMITTED:
THREE(3) COPIES TO BE MADE : 1 X Copy to Home 1 X Copy to Workshop Supervisor 1 X Copy for own File	

DEGREE OF DISABILITY

FORM 10

PLEASE ASSESS THE FOLLOWING TO DETERMINE THE LEVEL OF CARE: SELF CARE, MODERATE CARE, AND MAXIMUM CARE.

NAME OF MHCU _____ **D.O.B.**_____

1. MOBILITY	YES	NO
Moves independently		
Needs assistance, partial supervision and supervision with mobility		
Can climb up and down stairs		
2. PERSONAL HYGIENE		
2.1 ORAL CARE		
Completely independent		
Requires supervision		
Requires assistance		
2.2 BATH/SHOWER		
Completely independent		
Requires supervision		
Requires assistance		
Totally dependent		
2.3. TOILET HABITS		
Self sufficient		
Complete control of functions		
Requires supervision with use of toilet		
Periodic accidents		
3. EATING AND DRINKING HABITS		
Completely independent		
Requires supervision		
Requires assistance		
Totally dependent		
4. DRESSING		
Dresses and undresses completely independently		
Needs assistance or supervision with buttons, zips, shoelaces		
5. COMPREHENSION		
Good ability to follow simple instructions and to understand		
Able to follow simple instructions but poor understanding		
Unable to follow either simple instructions or understand		
6. ORIENTATION (TIME, PLACE, AND PERSON)		
Normal		
At times disorientated		
Often disorientated, restless, wanders		
Continuously disorientated, but does not disturb others		
Total disorientation, goes astray and disturbs others		

7. GENERAL MENTAL CONDITION		
Normal		
At times disturbed or confused		
Completely disturbed, confused or psychotic		
8. COMMUNICATION CAPABILITY		
Normal communication		
At times unable to communicate desires/ needs		
Total absence of communication		
9. WORK ABILITY		
Able to work in sheltered employment/ open labour market		
Able, after instructions, to perform protected work with little supervision		
Requires regular supervision to perform protected work		
Unable to perform protected work		

10. **NEEDS STRENGTH AND LIFE STYLE RISKS** indicate with a √

BELONGING	MASTERY	INDEPENDENCE	GENEROSITY	LIFESTYLE RISKS	
Lonely	Avoids risks	Undisciplined	Over involved	Aggressive	Racism
Distrusting	Fears	Lacks confidence	Over submissive	Substance abuser	Improper sexual behaviour
Craves affection	Unmotivated	Easily influenced	Selfish	Smoker	swearing
Craves acceptance	Gives up easily	Responsible	caring	Demanding	Vandalism
Isolated	Achiever	Appropriate choices	sharing	Manipulating	Self mutilation
Depressed	Problem solver	Inner control	Loyal	Family conflict	Hygiene problem
Family involvement	Motivated	Self-discipline	Considerate	Restless	Obsessive/ Compulsive
Attached/intimate	Competent	Leadership	Empathetic	Wander	hallucinations
Trusting		Assertive	Supportive	Theft	Lying
Friendly /happy relationships		Submissive		Uncontrollable	Suicidal

Social Worker's Evaluation and Recommendation:

Copy to be sent to be sent to the Facility

ASSESSMENT DONE BY:

Print name	**Signed:**
Print names of those involved in evaluation:	
Date of evaluation:	

SOCIAL WORKERS BASELINE SKILLS EVALUATION FOR MHCU'S APPLYING FOR ADMISSION TO WORKSHOPS

Name of MHCU:_____

Identity No:_____

Comment on the following areas of competence:

Personal presentation:

Social presentation:

Task competence:

Coping skills:

Quality of work:

Please supply the following information as well:

1. Diagnosis: intellectually disabled, psychiatrically disabled, epileptic, Down's syndrome, other ?

   _____

2. Does the mhcu have any behavioural problems? Specify

   .

   _____

3. **Client details [form 9]** on each applicant must be completed and it must accompany the client on admission to the workshop.

Social Worker.....

Date: .....