



SSP DB Number:

Tel: 046-622 9654 | 1 Lucas Meyer Avenue | Grahamstown | 6139
 web: <http://www.somersetplace.net> | email: admin@somersetplace.net

APPLICATION PACK

ADMISSION OF OLDER PERSONS AT SOMERSET PLACE SOCIETY

Please select one or a combination of the following, whichever is applicable to your application

Independent Living
 Complete Part A,B,E

Assisted Living
 Complete Part A,B,C,E

Frail Care
 Complete Part A,B,C,D,E

Somerset Place Society is registered in terms of relevant Legislation. Somerset Place Society is wholly self-funded and receives no subsidies or grants from any organ of state nor NGO.

ADMISSION CRITERIA

The following factors are the criteria for admission to Somerset Place Society:

- 1.1 All applicants must be 60 years of age or older.
- 1.2 Disabled persons younger than 60 years can only be considered for admission to Frail Care and Assisted Living with the consent of the Governing Body appointed at the time of application.
- 1.3 Applicants who are physically frail or who can no longer function independently may only apply for admission to Assisted Living or Frail Care if the relevant medical criteria is met.
- 1.4 Somerset Place Society is not a palliative care facility and nursing / carer procedures are limited to those prescribed under relevant professional association scope of practice.
- 1.5 The consideration and degree of frailty will be determined according to a departmentally approved scale/measuring instrument.
- 1.6 The facility's available care services and the necessary infrastructure will be considered.
- 1.7 Criteria contained in the following documents will apply at all material times:
 - 1.7.1 House Rules regarding the Residential Facility.
 - 1.7.2 Smoking Policy.
- 1.8 People with a history of the following conditions will not qualify for admission:
 - 1.8.1 Substance or drug dependence; Rehabilitated dependents must have been sobered for a reasonable period before admission. Proof of rehabilitation may be

requested.

1.8.2 People with an acute psychiatric condition.

1.8.3 A history of uncontrollable behaviour.

2. **THE RIGHT TO ADMISSION**

No older person will be refused admission to the residential facility if they meet the basic admission requirements. If someone cannot be accepted, the Manager will provide the applicant with the reasons in writing.

The following procedures form part of the Admission Policy.

3. **APPLICATION PROCEDURES**

Application forms are available at Somerset Place Admin Offices or Frail Care unit and applications will only be considered when the applicant and/or the relative or proxy has completed the following documents in full:

- 3.1 Application form with personal information. Completed by the applicant and or/proxy.
- 3.2 Medical report: Completed by a Doctor.
- 3.3 Chronic Medication Certificate. This is completed by the Doctor/Clinic/ Pharmacist if the applicant uses chronic medicines.
- 3.4 If the Older person presents with chronic mental health impairment a psychiatric report: Completed by a Medical Officer/GP or Psychiatrist and only if relevant.
- 3.5 Financial declaration: Completed by the applicant or proxy.

4. **CONSENT TO ADMISSION**

In terms of section 21 (3) of the Older Persons Act (Act 13 of 2006), the following requirements are set for admission to a residential facility:

- An older person may not be admitted to a residential facility without his/her consent, unless his/her mental condition makes him/her incapable of giving such consent. In that case, a proxy in terms of the Act or a court order must give the necessary consent.
- In the absence of a proxy, the older person's spouse or life partner may give consent. In the absence of a spouse or life partner, an adult brother or sister may give consent or otherwise the Minister must give consent.
- A medical practitioner, registered in terms of the Health Professions Act, 1974 (Act 56 of 1974) can certify that a delay in the admission of an older person to a residential facility could lead to his/her death or cause irrevocable damage to his/her health.

- Before admission, the Manager of a Residential Facility must ensure that all reasonable steps have been taken to obtain the older person's consent for admission. If an applicant is not able to apply him/herself and to give consent, a consent form must be completed on behalf of the applicant.

5. SCREENING PROCEDURES

- 5.1 The General Manager will screen and consider applications in respect of Independent Living applications.
- 5.2 The Frail Care Manager in conjunction with the General Manager or Medical Officer seated on the Medical Sub0Committee of the Governing Body will screen and consider all applications in respect of Assisted Living and Frail Care applications respectively.
- 5.3 All decisions by the screening committee are minuted and reported to the Management Board.
- 5.4 The applicant is informed in writing of the decision.
- 5.5 The applicant's name is placed on a waiting list if he/she qualifies for placement and there is no vacancy available at the time of approval.
- 5.6 For Independent Resident Applications, a waiting list fee shall apply which is reviewed annually by the Finance Sub-Committee and payable on or before 1 April each year.

The current waiting list fee is R145 per annum

6. ADMISSION PROCEDURES

The applicant and/or proxy are notified of the date for Admission. The following documents are discussed with the relevant parties as part of the admission procedure before signing:

Independent Living	Assisted Living	Frail Care
<ul style="list-style-type: none"> • Life Right Agreement is concluded. • Welcome pack provided to the new resident. • Unit Paid for by Resident. • Resident takes occupation. • Completion of Snag List. • Financial Implications <p>Mandatory Forms</p> <ul style="list-style-type: none"> • Living Will / Directive • POPIA Consent Form • Surety Form • Complex Rules • Power of Attorney (if required) • Medical Aid, ID • CCTV Acknowledgement 	<ul style="list-style-type: none"> • Living Will / Directive • POPIA Consent Form • Surety Form • Complex Rules • Power of Attorney (if required) • Medical Aid, ID • CCTV Acknowledgement • Financial Implications 	<ul style="list-style-type: none"> • Living Will / Directive • POPIA Consent Form • Surety Form • Complex Rules • Power of Attorney (if required) • Medical Aid, ID • CCTV Acknowledgement • Financial Implications

In terms of South African Legislation, the power of attorney lapses immediately when the person who has given it is no longer able to make important decisions or does not understand documents that must be signed. In such cases, a curator is appointed by a court to manage the person's affairs.

The applicant and/or relative and/or proxy hereby declares that they know and understand the contents of this application and the financial implications of taking residence at Somerset Place Society.

Applicant Name	
Applicant Signature	
Application Date	

Proxy/Relative Name	
Proxy/Relative Signature	
Date of Signature	

Witness Name	
Witness Signature	

PART A

PERSONAL DETAILS

(For completion by applicant or proxy)

1. Surname and Name called: _____
2. Full first names: _____
3. ID number: _____
4. Contact details:

The address of where you live at present:

_____ Postal Code: _____

Telephone no: _____ Mobile: _____

e-Mail (Resident): _____

e-Mail (Accounts): _____

5. Place of birth (Country): _____

6. Gender: Male Female

7. Marital status: Indicate with an (X).

Married	<input type="checkbox"/>	Widow/Widower	<input type="checkbox"/>
Never married	<input type="checkbox"/>	Divorced/Estranged	<input type="checkbox"/>

8. Name of Spouse or Life Partner, if married: _____
9. Home Language: _____
10. Church membership: _____
11. Level of education: _____

12. Former occupation: _____

13. Former occupation of spouse (if applicable): _____

14. Name of GP/Medical Practitioner: _____

Tel No of GP: (Practice) _____ (Mobile) _____

15. Name of Pharmacy: _____

Tel No of Pharmacy: _____ (Mobile) _____

16. Name of Medical Fund: _____

17. Membership number: _____

18. Do you have a funeral policy/Policy to cover your funeral costs?: _____

19. If Yes, Insurance company: _____

20. Policy number: _____

21. If you do not have a policy, explain what arrangements have been made in the case of death:

22. Name of funeral undertaker: _____

23. Tel: undertaker: _____

24. Contact person on death and telephone number: _____

25. Do you have a Will? Yes No

If "yes" where is your will kept? _____

Who is the executor? _____

26. Do you have a living will? Yes (Please provide a copy) No

Please continue to the next page.....

27. Details of **ALL** children (or next of kin, if no children):

Name & Surname	Address	Contact details	Relationship	Occupation
		Telephone: Cellphone: Email:		
		Telephone: Cellphone: Email:		
		Telephone: Cellphone: Email:		
		Telephone: Cellphone: Email:		
		Telephone: Cellphone: Email:		

28. Are there children/family who will sign surety? YES NO

Name: _____ Tel: _____

Name: _____ Tel: _____

29. Have you applied to any other Residential facilities? YES NO

29.1 If you answer is "Yes" please provide further information:

30. Occupation required on or before:

_____ (date)

31. Name of your nominated person or proxy who may act/deal on your behalf:

Name: _____ Identity number: _____

Address: _____

E-Mail address: _____

Telephone number: _____ Cell phone number: _____

All correspondence will be sent to this person, for example regarding annual fee adjustments, etc.

32. I herewith declare that the details provided in this application form are true and valid to the best of my knowledge. On admission, I undertake to comply with the complex rules as amended from time to time.

All fees are revised annually and effective as on 1 April each year.

I apply voluntarily for admission to **Somerset Place Society** in terms of the Older Persons Act (Act 13 of 2006) Section 21(3)(a).

Applicant Name	
Applicant Signature	
Application Date	

Proxy/Relative Name	
Proxy/Relative Signature	
Date of Signature	

Witness Name	
Witness Signature	

PART B

PERSONAL ASSESSMENT

(This report is completed by the applicant or family member/s)

1. APPLICANT'S PERSONAL INFORMATION

Full names: _____

Present address: _____

Present telephone/cellphone number: _____

Identity number: _____

Marital status: _____ Contact person : _____

Telephone number of contact person.: _____

2. INFORMATION SOURCES

Family members		Community members		Other
Home carer		Hospital personnel		
Minister		Social Worker		

3. CURRENT HOUSING/LIVING ARRANGEMENTS

House Owner		Tennant		Flat	
Retirement Complex		Guest House		Housing scheme	
Farm					

4. ACTIVITIES OF DAILY LIVING (Please tick one box per activity)

	Eating & Cooking	Dressing & Undressing	Personal Hygiene & Care	Cooking & Eating	Toilet Use	Medication	Mobility	Communicating	Gardening	Going to Town or Visiting
Fully independent										
Dependent on aids										
Needs supervision but can manage										
Needs regular supervision & help with certain tasks										
Needs help of one person										
Needs help of two persons										
Needs full-time care										

General Remarks:

5. MENTAL HEALTH:

No support needed.	
Needs minimal supervision and support.	
Needs fulltime supervision & support.	
Any diagnosed Mental Health Condition?	
If yes to the above, please give further details:	
Any suspicions of diagnosis of Dementia, Alzheimer's etc?	
Good Short Term Memory – recent interactions, decisions, names, etc	
Good Long Term Memory – memories of Childhood, Adolescence, Significant Life events.	
Remarks:	

6. SUPPORT SYSTEM AVAILABLE

Support system (spouse; family and friends) functions well	
Support system available, but does not function well	
Lives alone with access to other support systems	
Only other formal support systems	
Support system available but exploitation/abuse/neglect suspected	
No support system available	

7. GENERAL FUNCTIONING OF CURRENT CARER (If applicable)

Carer in full control of the situation	
Carer needs help at times	
Carer is aged/disabled/not healthy	
Carer needs full-time help	
Carer totally incapable of controlling the situation	

Carer emotionally burnt out	
-----------------------------	--

Name of Person Completing this form	
Occupation	
Applicant Signature	
Application Date	

PART C

SOMERSET PLACE SOCIETY ASSESSMENT / EVALUATION FORM

This form is to be completed by the Frail Care Manager or Registered Nurse:

Name of resident: _____

Date of birth: _____

Select the relevant description under each section and tick the appropriate box.

NOTE: In the event that any answer to the following questions is not answered fully independent then Somerset Place Society, if so requested will require further tests and investigations to be carried out by a professional to determine the extent, diagnosis and prognosis.

		Totally Independent	Requires Assistance	Fully Dependent
A	Walking without an aid			
B	Walking with an aid			
C	Sitting and standing up			
D	Visual ability			
E	Hearing ability			
F	Mental Health, Memory			
G	Personal Presentation			
H	Communication ability			
I	Aware of surroundings			
J	Ability to operate a motor vehicle			
K	Administration of drugs / medication			

Name of Person Completing this form	
Occupation	
Signature	
Date	

PART D

MEDICAL REPORT

The medical report for admission to a Residential Facility is done at the cost of the applicant and is to be completed by a doctor.

1. Full Name and Surname: _____
2. Identity number: _____
3. Current address: _____

4. **GENERAL INVESTIGATIONS:**

- (a) Physical and nutritional condition: (normal/under-nourished)

- (b) Skin condition (threatening or existing bed sores):

- (c) Free of infectious illnesses: YES/NO - Specify if No, what illnesses (e.g. TB)

- (d) Type of treatment:

- (e) Type of operations undergone:

Type

Date

Type

Date

Type

Date

5. **MENTAL / PSYCHOLOGICAL ABILITIES:**

Good

Fair

Poor

Specify: _____

6. **CARDIOVASCULAR:**

- (a) Blood pressure: _____ Pulse: _____ SPO²: _____
- (b) Is patient on Betablockers? YES / NO

- (c) Is patient on other hypertensives: YES / NO

- (d) Has patient ever had ischemic myocardial heart illnesses? YES / NO
Explain: _____
- (e) High cholesterol: YES/NO

7. **RESPIRATORY SYSTEM:**

- (a) Respiratory or cardial asthma: YES / NO _____
- (b) Chronic bronchitis: YES / NO _____
- (c) Emphysema YES / NO _____
- (d) Pulmonary Tuberculosis YES/NO _____
- (e) OTHER (specify): _____

8. **DIGESTIVE SYSTEM:**

Diabetes	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>
Liver diseases	<input type="checkbox"/>	Ingiunal hernias	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>		

Special Diets: Specify: _____

Other: _____

9. **UROGENITAL SYSTEM:**

- (a) Incontinence YES / NO
If YES, does the patient have a permanent catheter? YES / NO
If YES, does the patient use nappies? YES / NO
- (b) Urine **Macroscopic:** Clear YES / NO
Albumin YES / NO

Proteins YES / NO
 Blood YES / NO

Microscopic: Sugar YES / NO
 Blood YES / NO
 Albumin YES / NO

10. CENTRAL NERVOUS SYSTEM:

- (a) Tremors: _____
- (b) Parkinsons: _____
- (c) Multiple Sclerosis: _____
- (d) Motorneuron Illness: _____
- (e) Epilepsy: _____
- (f) Other: _____

11. MUSCLE AND SKELETAL SYSTEM:

Osteoporosis	<input type="checkbox"/>	Osteo-arthritis	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	Hemiplegic	<input type="checkbox"/>
Myopathy	<input type="checkbox"/>	Quadriplegic	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>		<input type="checkbox"/>

12. SENSES:

(a) **Sight** GOOD / POOR/ BLIND _____

Glasses Contact lenses

(b) **Hearing** GOOD / POOR/ DEAF _____

Hearing aid

**13. HAS THE RESIDENT HAD PROBLEMS WITH ALCOHOL/SUBSTANCE ABUSE?
 (PLEASE DESCRIBE)** _____

14. HAS THE RESIEDENT ANY IDENTIFIED ALLERGIES? YES / NO

Medication : _____

Food types : _____

Other Information: : _____

15. **MENTAL STATE (Mark with an X):**

Normal
Dementia/Alzheimer
Insomnia
Aggressive behaviour
Neurosis
Psychosis

Depression
Schizophrenia
Restlessness
Anxiety
Bipolar depression
Parkinsons

How long have you been treating the resident for the above conditions? _____

16. **PRESCRIBED MEDICATION:**

Current: _____

Chronic medication: _____

Follow up visits for tests and repeat medication: Dates for tests: _____

Dates for repeat of prescriptions: _____

17. **SPECIFY INSTRUCTIONS FOR FOLLOWING VISIT/EVALUATION:** _____

18. **ANY OTHER ILLNESSES NOT SPECIFIED:** _____

19. **GENERAL COMMENTS:** _____

20. **HOW LONG HAVE YOU BEEN TREATING THE PATIENT?** _____

21. **DOES THE PATIENT VISIT ANY OUT-PATIENT CLINICS AT PRESENT? YES / NO**

If YES, where? _____

Doctor Name: _____

Signature: _____

Date: _____

MP Number: _____

PART E**FINANCIAL DECLARATION**

(This form is completed by the applicant or the proxy)

Documentary proof of all income/expenditure must be attached plus 3 months bank statements

Name of Applicant:	
Date of Completion:	

i. INCOME

TYPE	FREQUENCY	SOURCE	SELF - A	SPOUSE - B
Salary / Wages				
Pension/Provident				
Retirement Annuity				
Trust Funds				
Shares				
Cash Investments				
Property Rental				
Foreign Income				
Family Allowance				
Other – specify				
Other – specify				
Other - specify				
Sub Total:				
			Monthly Total	
			(a+b)	

ii. DECLARATION OF ASSETS: (Please complete in full)**a. ASSETS** – My total asset value – please tick appropriately

R2million
 R3million
 R4million
 R5+million

I declare that the above information provided by me, is true and valid to the best of my knowledge and that the declared income is all of the applicant's income for the tax year.

SIGNATURE OF APPLICANT/PROXY

DATE

DECLARATION

I certify that, before I administered the prescribed oath/confirmation, I put the following questions to the declarant and wrote down his/her answers in my presence.

- (a) Are you familiar with the content of this declaration and do you understand it?
Answer: _____
- (b) Have you any objection to taking the prescribed oath?
Answer: _____
- (c) Do you consider the prescribed oath to be binding on your conscience? Answer: _____

I certify that the declarant is familiar with the content of the oath and understands it. This declaration was sworn to/confirmed before me and the declarant's signature/thumb print was inserted in my presence.

COMMISSIONER OF OATHS	NAME & SURNAME	
DATE	PLACE	STAMP

FOR OFFICE USE: SOMERSET PLACE SOCIETY

Date Application received: _____
 Received By: _____
 Date of Committee Meeting: _____
 Comments: _____

Application Result: APPROVED / NOT APPROVED / PENDING

ADDITIONAL REQUIREMENTS SET DOWN: _____

CHECK LIST:

- | | |
|--|--|
| <input type="checkbox"/> Application Completed and signed | <input type="checkbox"/> Surety Completed |
| <input type="checkbox"/> Copy of Identity Documents for Individual & Surety | <input type="checkbox"/> POPIA Completed |
| <input type="checkbox"/> Self-Assessment Completed | <input type="checkbox"/> CCTV Completed |
| <input type="checkbox"/> Medical Questionnaire completed | <input type="checkbox"/> Living Will Completed |
| <input type="checkbox"/> Power of Attorney Completed – <i>not compulsory</i> | |
| <input type="checkbox"/> Financial Documents attached | |

Signed off by: _____ on this _____ day of _____ 20____

Signature: _____



POWER OF ATTORNEY FORM

GENERAL POWER OF ATTORNEY

Know all Men whom it may concern:

That I, the undersigned,

(hereinafter called the *Mandant*)

do hereby nominate, constitute and appoint the undersigned, Name & ID No:

(hereinafter called the *Agent*)

to be the Attorney and Agent of the *Mandant* with power generally to represent the *Mandant* and to manage and transact all and every manner of business in which the *Mandant* may in any way be interested or concerned personally or otherwise and in particular to do or cause to be done any of the acts, matters or things following – without however, limiting the generality of this Power of Attorney thereto, viz:-

- (a) To acquire, deal with, recover, take possession of, receive and dispose of any property, goods, effects, moneys, securities, deeds, documents of any kind whatsoever.
- (b) To adjust, debate, settle any account or dispute and to enter into any compromise, make any abatement in regard to any claim by or against the *Mandant*, to act for and represent the *Mandant* in regard to any legal proceedings whether as Plaintiff, Defendant, Applicant, Petitioner, Appellant, Respondent or otherwise and whether by action, application, motion, petition or otherwise and to choose domicilium citandi et executandi and to settle or adjust any such matters and to submit or agree to submission of any matter to arbitration and to perform or enforce the performance of any award of judgement in any such matter or to make any agreement in regard thereto.
- (c) To act in any way in regard to any assignment or to do any act under any l.a.w. relating to assignments, insolvency or bankruptcy, and to do or perform any act which the *Mandant* could do or perform in connection with any estate in any Master's Office or other public office or otherwise in insolvency, assignment, or in the case of deceased persons under any legal disability or otherwise, including herein the power of executing deeds, documents, granting receipts acquaintances, appearing at meetings and voting, proving or admitting claims and generally doing whatever the *Mandant* could do in any such matters.
- (d) To act in any way for the *Mandant* in regard to any business whether solely or in partnership with others or in regard to any Syndicate, Company, Society,

Association, Corporation or Institution and to sign any Memorandum or Articles of Association or other deed or document relating thereto, and to promote or establish or incorporate the same and to act in any way in the liquidation or winding up of any Business Partnership, Syndicate, Company, Society, Association, Corporation or Institution, to acquire and dispose of, cede or transfer or otherwise act in regard to any Policy of Insurance of any kind, interest, share, stock, debenture in any Business, Partnership, Company, Society, Association, Corporation or Institution of any kind, and to receive any money or other property whether as Capital, Interest, Dividend or otherwise.

- (e) To transact any business with or in any Bank and to open, operate upon any account with any Bank, whether an Ordinary Bank or Savings Bank or other similar institution, to draw, sign, make, accept, endorse any Cheques, Bills, Drafts, Promissory Notes or Money Orders, Postal Orders, Postal Notes or other Securities or Instruments negotiable or otherwise and in any manner to deal therewith.
- (f) To enter into any contract, suretyship, guarantee, indemnity, relating to any matter whatsoever, to raise, borrow or invest money on any terms, to let and hire movable or immovable property, and to enter into any Charter Party or other deeds or transactions in connection with shipping freight or transport by land, air or water or otherwise, and insurance of any kind.
- (g) To deal with and dispose of any property, movable or immovable, or rights or interest therein in any manner whatsoever, and in particular to execute any act or deed relating to alienation, partition, exchange, transfer, mortgage, hypothecation or otherwise in any Deeds Registry Mining Title Office, or other Public Office, or relating to servitudes, usufructs limited interests or otherwise and to make any applications, grant any consent or agree to any amendment, variation, cancellation, cession, release, reduction, substitution or otherwise generally, relating to any Deed, Bond or Document, and to obtain copies of Deeds, Bonds or Documents for any purpose and generally to do or cause to be done any act whatsoever in any such office, including herein the passing of any Notarial Deed or Bond for registration in any such office or the performance on any act relating thereto.
- (h) To assist or concur in any matter or thing done or to be done or any document or instrument executed or to be executed by any other person. under coverture or legal disability or any kind and for which matter or thing or document or instrument the assistance of concurrence of the *Mandant* may be requisite.
- (i) To engage or discharge servants or employees of any kind.
- (j) Generally, regarding any of the matters above specified to do all such further acts as may be auxiliary to the purposes aforesaid, and to act generally in regard to any matters in addition to those herein before mentioned and to do whatever the *Mandant* could do.

The said Agent is further authorised to appoint any substitute (with or without power of substitution) to do all or any of the acts or thins which the Agent under the Power could do and also to cancel or modify any appointment and to make any other similar appointment,



**CONSENT FORM FOR ADMISSION IN A RESIDENTIAL CARE FACILITY ON BEHALF OF AN
OLDER PERSON
IN TERMS OF**

SECTION 21(3) (b) (i) OF THE OLDER PERSONS ACT, 2006 (ACT NO. 13 OF 2006)

I _____ (name and surname)
ID no _____
staying at residential address _____

Telephone number _____ hereby give consent in terms of section 21 (3)(b)
(i) for _____ (Name and Surname of Older Person) to be
admitted in a Residential Care Facility) ID no _____
to be admitted at **Somerset Place Society, 1 Lucas Meyer Avenue, Grahamstown, 6139.**

Signature of person giving consent: _____

Relationship to Older Person: _____

Date: _____

WITNESS/ADDITIONAL FAMILY MEMBER:

1. _____

2. _____



Tel: 046-622 6217 | 1 Lucas Meyer Avenue | Grahamstown | 6139
 web: <http://www.somersetplace.net> | email: admin@somersetplace.net

SURETY

I, _____, Identity Number _____ the undersigned
 with physical address,

, do hereby bind myself as surety and co-principle debtor with the flat rental / life right in respect of
 _____, Identity Number _____ for all
 his/her obligations to Somerset Place Society, and I specifically renounce the benefit of excussion.

SIGNED AT _____ on this _____ day of _____ 20____

 Capacity: Surety & Co-Principal Debtor

 NAME & SURNAME (Print)

WITNESS:

3. _____

4. _____



Tel: 046-622 9654 | 1 Lucas Meyer Avenue | Grahamstown | 6139
web: <http://www.somersetplace.net> | email: admin@somersetplace.net

CCTV ACKNOWLEDGEMENT FORM

Somerset Place Society

This form serves as an official acknowledgment of the presence and purpose of Closed-Circuit Television (CCTV) surveillance at Somerset Place Society.

1. ACKNOWLEDGMENT

I, _____ residing at _____, acknowledge that Somerset Place Society operates CCTV cameras for the safety and security of residents, visitors, and staff.

2. PURPOSE OF CCTV SURVEILLANCE

I understand that CCTV monitoring is conducted to:

- Enhance security and prevent unauthorized access
- Maintain a safe living environment for residents
- Assist in incident investigation if necessary
- Ensure compliance with Society policies

3. PRIVACY, DATA PROTECTION & DATA RETENTION

I acknowledge that:

- CCTV footage is strictly used for security purposes and is not shared beyond authorised personnel.
- Access to recorded footage is restricted and governed by Society policies and applicable laws.
- CCTV cameras are placed in common areas and do not monitor private residences.
- Privacy masks shall be employed where a common area CCTV camera has visibility of a residents windows or doors.
- CCTV cameras in Frail Care and Assisted Living is deployed in all common areas, bedrooms and lounges for response purposes and shall only be monitored by Nursing Staff at the Nurses Station in Frail Care.
- CCTV Footage of all Cameras are stored on the Network Video recorder for a period not exceeding 3 months.

- Where events recorded on camera have been tagged then such tag will remain in force until such time that the incident is managed and finalised in accordance with incident management protocols or the disciplinary code and procedures, or alternatively deleted after 3 years unless such camera footage is criminal in nature it will not be deleted until such time that authorities have concluded such investigation.
- All requests for access to CCTV footage shall be made in writing as prescribed to the Information Officer of Somerset Place Society i.e. the General Manager.

4. CONSENT AND COMPLIANCE

I confirm my understanding of CCTV monitoring at Somerset Place Society and agree to comply with its security protocols.

Signature: _____

Name: _____

Date: _____



Somerset Place Society

RETIREMENT VILLAGE, ASSISTED LIVING & FRAIL CARE

DO NOT RESUSCITATE (DNR)

Patient's full legal name: _____

Date: _____

PHYSICIAN STATEMENT

I, the undersigned, state that I am the physician of the patient named above and I affirm that this order is consistent with the patient's wishes. I hereby direct any and all qualified health care personnel to withhold or withdraw cardiopulmonary resuscitation (cardiac compressions, intubation and other advanced airway management, artificial ventilation, defibrillation and other related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such health care professionals to provide comfort care to the patient such as fluids, oxygen or other treatment deemed necessary to provide comfort and alleviate pain. A copy of this will be kept in the patient's records.

Physician's signature: _____ Date: _____

Physician's printed name: _____ MP No. _____

Witness: _____ Witness: _____

PATIENT STATEMENT

I, the undersigned, being of sound mind and legal age, wilfully and voluntarily make this declaration to state my desires and direct that resuscitation be withheld or withdrawn in the event of my cardiac or respiratory arrest. It is my intention that this order be honoured by my family, my physicians and all others who participate in my health care.

Patient signature _____ Date _____

Print patient name _____

Witness: _____ Witness: _____

FAMILY STATEMENT

I, the undersigned, being in possession of legal rights to make decisions on behalf of the patient (Power of Attorney) declare that resuscitation be withheld or withdrawn in the event of the patient's cardiac or respiratory arrest. (Please attach a copy of the Power of Attorney to this document).

Family signature _____ Date _____

Family Member _____

Witness: _____ Witness: _____



LIVING WILL

Should I no longer be able to make any decisions about my future or to consent to medical treatment, let this document stand as an explicit declaration of my wishes in the matter.

Full Name: ID

Number:

Address:

TO MY FAMILY AND MEDICAL PHYSICIAN:

1. Should I be physically ill or impaired causing me to suffer constant pain without a reasonable possibility of recovering or living a normal life again, I wish to be allowed to die in a dignified way and not be kept alive by machines or other artificial means.

Initial:

2. During such a time, I ask the medical physician responsible for my medical treatment to administer drugs necessary to keep me free from pain, and as comfortable as possible, even if it will shorten my life.

Initial:

SIGNATURES

I have signed and dated this document in the presence of the two undersigned witnesses.

Signed at on of 20 .

Testator

Witnesses: Witness 1

Witness 2

DISCLAIMER

Somerset Place Society cares about the legal rights of our residents. This living will has been designed with you and protection of your rights in mind. Although we have taken every care to ensure that this document is accurate and up to date with the law, it is important to remember that our law is constantly evolving and changing. We therefore cannot guarantee that the information is without any errors or omissions. Somerset Place Society and its employees will under no circumstances accept liability for the consequences resulting from the use this living will. We believe that it's important to always discuss legal matters with an attorney before making a decision or signing any document.



Somerset Place Society

RETIREMENT VILLAGE, ASSISTED LIVING & FRAIL CARE

CONSENT TO PROCESS PERSONAL INFORMATION FORM

In terms of (Section 18) of the Protection of Personal Information Act, 2013 (Act No. 4 of 2013)

Name:

Contact Number:

Email Address:

Section A. Purpose for Collection and Processing the Information

The purpose for the collection of your Personal Information and the reason for Somerset Place Society requiring your Personal Information is to enable the Company:

- i. to comply with lawful obligations, including amongst others, all applicable labour, tax and financial legislation such as:
 - The Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS)
 - The Financial Intelligence Centre Act 38 of 2001 (FICA)
 - The Older Person Act, Act 13 of 2003, as amended
- ii. to give effect to a contractual relationship between the Somerset Place Society and yourself;
- iii. to conduct its business operations; and
- iv. to protect the legitimate interests of Somerset Place Society, yourself and or any third parties.

All Personal Information which you provide to Somerset Place Society will only be used for the purposes set out above.

Section B. Declaration and Informed Consent

I consent to providing the Personal Information required to Somerset Place Society, on the understanding that Somerset Place Society is responsible to abide by the principles set out in POPIA, in the Somerset Place Society POPIA Policy, and in this document.

I declare that all Personal Information being supplied by me to Somerset Place Society is accurate, up to date, not misleading, and that it is complete in all material respects.

I undertake to advise Somerset Place Society immediately of any changes to my Personal Information, should any of the details change.

By providing Somerset Place Society with my Personal Information, I consent and give Somerset Place Society permission to process and further process the Personal Information, as and when required, that I supply to Somerset Place Society, understanding the purposes for which Personal Information is required and for which it will be use.

First Name and Surname:

Signature:

Date: