LITTLE ANGELS HOME APPLICATION

All information is treated as confidential.

Complete this application, attach a copy of the applicants Disability Assessment, ID and Road to Health Card and email it all to Tanya at operations@littleangelshome.co.za

Please take note of the following application requirements:

All applicants need to be 10 years and younger.

Once the applicant has been placed into Little Angels Home, it is important to take note of the following age restrictions: Full time care: 0 - 18 years.
Once the learner has reached the maximum age, alternative care arrangements need to be made by the parents / guardian.
Applicants need to be moderately disabled and wheelchair dependent. Applicants need to be RSA citizens. Little Angels reserves the right of admission.

Please note that Little Angels will request the following information of the parents / guardian, during the assessment of the application:
- 3 Months Bank Statement
- Proof of Address
- Copy of ID's

Please get in touch if you have any questions regarding the application. Upon admission of an applicant, an additional contract will need to be signed.
Should Little Angels be filled up to capacity, the applicant will be placed on a waiting list and the management team will let you know as soon as a spot opens up.

Take note that we are a care facility and not a medical facility.

APPLICANTS DETAILS

e.g *person applying on behalf of the learner*

Full Name & Surname:		Tel:	
Relation to Resident:		Mobile:	
Email:		Application Date:	

RESIDENTS DETAILS

e.g the learner that would like stay at Little Angels Home

Full Name & Surname: _____ RSA ID Number: _____

Gender: _____ Date of Birth: _____

Home Language: _____

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

Code: _____ Code: _____

PARENTS / GUARDIANS DETAILS

MOTHER

Full Name & Surname: _____ RSA ID Number: _____

Marital Status:
(single/married/divorced) _____ Occupation: _____

Email: _____ Employer: _____

Mobile No: _____ Work No: _____

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

Code: _____ Code: _____

FATHER

Full Name & Surname: _____ RSA ID Number: _____

Marital Status:
(single/married/divorced) _____ Occupation: _____

Email: _____ Employer: _____

Mobile No: _____ Work No: _____

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

Code: _____ Code: _____

GUARDIAN

Full Name & Surname: _____ RSA ID Number: _____

Marital Status:
(single/married/divorced) _____ Occupation: _____

Email: _____ Employer: _____

Mobile No: _____ Work No: _____

Residential Address: _____ Postal Address: _____

_____ _____

_____ _____

Code: _____ Code: _____

NEXT OF KIN

Full Name & Surname: _____ Mobile No: _____

SIBLINGS IN HOUSEHOLD

Full Names & Surnames:	Date of Birth:	Gender:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

MEDICAL HISTORY OF RESIDENT

Medical Aid Name: _____

Type of Medical Plan: _____

Main Member: _____

Description of Disability: _____

_____

_____

_____

_____

Medical Aid Number: _____

Dependant Code: _____

Main Member ID No: _____

Disability Type: _____

Is the resident toilet trained *(yes/no):* _____

Is the resident self feeding *(yes/no)* : _____

Is the resident self grooming *(yes/no):* _____

Is the resident wheelchair bound *(yes/no):* _____

Health Conditions
(tick relevant boxes):

If you ticked any of the boxes above, please describe condition in depth:

Epilepsy	☐	
Diabetes	☐	
Rheumatic Fever	☐	
Seizures	☐	
High/low Blood Pressure	☐	
Heart Problems	☐	
Asthma / Lung Condition	☐	
Other	☐	

Medication Name:

Dosage & times per day taken:

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____
5. _____ 5. _____

Details of any allergies: _____

Resident's medical history (any illnesses, operations or surgery):

Relevant family medical history:

Family Doctor:

Contact No:

Specialist:

Contact No:

Psychiatrist:

Contact No:

Primary Hospital:

Contact No:

INDEMNITY & CONSENT

Consent Information

From time to time, the centre will require photographs of the residents for publication in the press, annual reports or any other articles published by the centre. All staff members, including interns, working with the residents need to view the information in their folders to assist with their development.
Please make a cross on the relevant box for all scenario's listed below:

- Photographs and/or videos may be taken of my child for in house use for ex. birthday parties, outings, etc.	Yes	No
- Photographs and/or videos may be taken of my child for extrenal use for ex. fundraising articles, press releases and Little Angels website	Yes	No
- My child's name and/or diagnosis may be used with photographs	Yes	No
- My child may be transported by the centre	Yes	No
- All staff may view the contents of my child's folder	Yes	No
- The centre may administer medication (prescribed by the doctor) to my child. *Please do not put medication in the child's case/bag, but hand it to the assistant on the vehicle.*	Yes	No

Indemnity Information

I indemnify and undertake to bring no legal proceedings of whatsoever nature or kind, against the Centre and/or any of its Board of Management Members and/or any of its various Committee Members and/or any of its staff members and/or any beneficiary for all or any claims for damages of whatsoever arising out of injury or loss or harm of whatsoever kind, sustained by reason of the use and/or being on the centre's premises, transport or equipment. I acknowledge that Little Angels Home is not a medical facility, but a care facility (emergency care is provided by contracted EMO's). The Centre only insures its own property. The onus is therefore on the parent/guardian to insure your child.

Full Name & Surname: _____

Signatory Relation to Resident: _____

Date: _____

OFFICE USE

Admission Date: _____

Centre Manager: _____

Signed by: _____

Comments: _____