QUADRANT GARDENS

LUXURY URBAN RETIREMENT

Application Process

To apply for a Life Right purchase at Quadrant Gardens, please review and complete the application form and accompanying documents that form part of this information pack.

The complete application form includes the following documents:

1. Personal Information – please indicate which CPOA Retirement Communities you are applying to under Options 1 - 3 in the top right corner.
2. Medical certificate – to be completed by physician who is not a family member.
3. Psychiatric report – only to be completed by a Psychiatrist or Psychiatric nurse if suffering from any mental disorder i.e. Dementia etc., or if currently seeing a Psychiatrist.
4. Annexure B – Income & expenditure
5. Acknowledgement of Debt
6. Deed of Surety – to be completed only if another individual is going to stand surety. This individual must be employed, show proof of income, provide 3 months banking details, copy of I.D., and if this individual lives abroad they must have a South African bank account.
7. Debit order instruction form

Once complete please return all application forms to CPOA Head Office via post, email or hand delivery. Once received by the designated Social Worker, he/she will make contact within 14 working days to arrange an Assessment interview with the applicant.

Thereafter, the application will be presented to CPOA's Selection Committee for a final decision and the Social Worker will again make contact to advise on the outcome of the application and next steps.

Please note that should a couple wish to apply, both applicants are required to complete separate application forms.

For more information or assistance, pleae contact CPOA on 021 686 7830.

CPOA
The Retirement Specialist

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STRICTLY PRIVATE AND CONFIDENTIAL

APPLICATION FORM FOR ADMISSION TO:

Option 1 ____________________________________
Option 2 ____________________________________
Option 3 ____________________________________

Please note: (a) That this form must be completed in Applicant's own handwriting.
(b) Completion of a CPOA Medical Certificate will be required.

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.			

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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 CAPE PENINSULA ORGANISATION FOR THE AGED 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 CAPE PENINSULA ORGANISATION FOR THE AGED 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. ____

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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 CAPE PENINSULA ORGANISATION FOR THE AGED to recover amounts owed.

2) the right of CAPE PENINSULA ORGANISATION FOR THE AGED 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. ______________________________

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PSYCHIATRIC REPORT

Name
Address
Age

Please cross only where applicable

In Patient	Out-Patient	Length of Treatment

Mental Condition

1. Schizophrenia, including hallucinations	
Schizophrenia, including delusions\	
paranoid ideas.	
Outward manifestations:	
2. Anxiety States	
Psychosomatic	
Obsessive-compulsive	
Hysteria	
Phobias	
Outward manifestations:	
4. Depressions	
Reactive\mild	
Endogenous\severe	
Manic-depressive psychosis	
Suicidal	
5. Acute disorders of delirium\confusion states	
Chronic dementia	
Degree	
6. Personality disorders	
Passive dependent	
Passive Aggressive	
7. Drinking problems	
Socially	
Chronic	
Brain Damage	
8. Epilepsy	
Controlled on medication? Yes	No
Remarks	

9. Mental retardation	
10. Drug Abuse	
11. Present functioning	
Personal Hygiene	
Mobility	
Orientation to changes	
Ability to Communicate	
Emotions\Alertness	
Behaviour	
Aggressive	
Abusive	
Wanders around	
Incontinent	
Other	
12. Prognosis	
13. Medication	
14. Treatment	

DATE: ___________________________ SIGNED ___________________________

Qualification of person completing the form:__________________ Address: ___________________________________

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MEDICAL CERTIFICATE IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO HOMES FOR THE AGED

(To be completed by a Medical Practitioner or District Surgeon)

N.B.: Replies to all questions are required to facilitate nursing and administrative arrangements.

1. SURNAME OF APPLICANT: ________________ FIRST NAME(S): ________________
   (In Block Letters)

2. APPLICANT'S COMPLAINTS (HISTORY, SYMPTOMS & PREVIOUS TREATMENT - STATE HOSPITAL WHERE TREATED):
   (Please Print)

   Medical: ________________

   Surgical: ________________

   Psychiatric: ________________

3. GENERAL EXAMINATIONS:

   a) General physical and nutritional state ________________ Temp: ________

      i) Weight/Mass: ________________ ii) Appetite: ________________

   b) Respiratory system ________________

   c) Cardio-vascular system ________________ Pulse: ________

      Hb: ________ B/P: ________

   d) Genito-urinary system ________________

      Dysuria: ________________ Urine test results: ________________

   e) i) Gastro-intestinal system ________________

      ii) Hernia ________________

   f) Masculor-skeletal system: Does the applicant suffer from? (Please delete terms not applicable)

      i) Osteoporosis ________________

      ii) Osteoarthritis ________________

      iii) Rheumatoid arthritis ________________

      iv) Locomotive disabilities ________________

      v) Hemiplegia ________________

      vi) Myopathies ________________

   g) 1. Central nervous system ________________

      1.1 Tremors ________________

      1.2 Parkinson's ________ Multiple Sclerosis: ________ Motor Neurone: ________

      2. Neuropsychiatric ________________ Other: ________________

   h) Endocrine system ________________ HGT: ________

   i) Ear, nose and throat ________________

   i) Eyes ________________

      i) Vision levels ________________

ii) Spectacles / contact lenses / implants ______

j) Does the applicant suffer from any disease of the skin? (Include bedsores, ulcers, etc.) ______

______

4. a) Degree of mobility ______

b) Is the applicant incontinent? Type: ______ Urine: ______ Faeces: ______

c) i) Has the applicant any communicable disease? (e.g. TB)

ii) Current treatment ______

d) i) Presence or suspicion of neoplasm, tumours? ______

ii) Treatment regime? ______

e) Has the applicant any known allergies or sensitivities? (If so, please detail) ______

f) Has the applicant any history of alcohol or drug dependency? (If so, please detail) ______ Smoker: Y / N

g) Dentition: ______ Caries: ______ Dentures: ______

h) i) Is the applicant's hearing: GOOD ______ PARTIALLY DEAF ______ DEAF ______ (Please tick appropriate box)

ii) Hearing aid use: Yes / No

i) Does the applicant require:

i) Regular assistance in respect of mobility, personal hygiene, medication and dressing or undressing? ______

______

ii) Constant and prolonged assistance regarding mobility, dressing or undressing, feeding and personal hygiene? ______

______

j) What is the applicant's mental condition?______ Mini-mental test result ______
(Please tick if one or more are applicable)

a) i) Normal ______

ii) Depression ______

iii) Senile Dementia ______

iv) Restlessness ______

v) Insomnia ______

vi) Anxiety ______

iv) Abusive and/or aggressive/violent ______

v) Behaviour Disorder ______

vi) Psychosis ______

b) i) Does the applicant have reasonable recall of recent events? ______

ii) Is applicant fully time-and-place orientated? ______

iii) Has the applicant any history of wandering from home? ______

5. HOW LONG HAVE YOU BEEN IN ATTENDANCE ON APPLICANT? (IF FIRST VISIT, NAME OF USUAL MEDICAL DOCTOR, DAY HOSPITAL CARD NUMBER IF APPLICABLE):

______

6. FURNISH DETAILS OF ALL CURRENT MEDICATION: ______

______

i) Please indicate signs to be watched for in respect of re-evaluation ______

______

ii) Follow-up dates for tests, surgery, and repeat prescriptions ______

______

7. GENERAL REMARKS: ____

____

____

____

____

Place: ________________________________ **Date**: ____________________

Signed: ________________________________ **General Practitioner/District Surgeon**

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ANNEXURE B

STATEMENT OF INCOME AND EXPENDITURE – ECONOMIC HOMES

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:

Commissioner of Oaths:

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DEBIT ORDER INSTRUCTION FORM

Name of Bank: ____

Branch Name: ____

Branch Number: | | | | | | | | |

Type of Account: Current (Cheque)\ Savings

Account No: | | | | | | | | | | | | |

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).

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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

N.B. When returning this form it must be accompanied by a payment of R50.00 (Fifty rand).
This is a non-refundable administrative fee.

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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:

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.
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.
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.

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ANNEXURE "A"

COPY FOR CPOA HEAD OFFICE USE

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.
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.
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.

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ADDENDUM

Any other pertinent information:

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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