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**LOGWOOD VILLAGE APPLICATION FORM**

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| **APPLICATION FOR:** | **Residential Centre** |  | **Day Care** |  |  |
| **Date of Application:** |  |  | | |

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| 1. **Applicant’s Information** | | | | | | | |
| Surname: |  | | | | | | |
| Full Name: |  | | | | | | |
| Nickname: |  | | | | | | |
| I.D. No. |  | | | | | | |
| Age: |  | Gender: | Male | | Female |  | |
| Date of Birth: |  | | | Place of Birth: | | |  |
| Applicants Disability (SASSA)Grant number: |  | | | | | | |
| Language: |  | | | | | | |
| Primary Diagnosis if any: |  | | | | | | |

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| **Previous Residential Facilities Attended:** | |
| Name of facility |
| Reason for leaving previous residential facility: | |
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| Are there any behavioural problems/issues/incidents or dangerous behaviour that we need to be made aware of? | |
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| **2. Parent / Guardian Information** | | |
| Parents/Guardians: Full names: |  | |
| I.D. Number: |  | |
| Physical Address: |  | |
| Email addresses: |  | |
| Employers’ Details: |  | |
| Occupation: |  | |
| Contact: | Home: |  |
|  | Work: |  |
|  | Cell: |  |
| E-mail Address: | Self: | |
|  | Work: | |

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| Second Parent / Guardian: Full names: | |  | |
| I.D. Number: | |  | |
| Physical Address: | |  | |
| Employer’s Details: | |  | | |
| Occupation: | |  | | |
| Contact tel. number: | | Home: |  |
|  | | Work |  |
|  | | Cell: |  |
| E-mail Address: | | Self: |  |
|  | | Work: |  |

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| **Other Contact Numbers:** | |
| Name: |  |
| Relationship to resident: |  |
| Tel: |  |
| Name: |  |
| Relationship to resident: |  |
| Tel: |  |

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| **Emergency Contact Number:** | |
| Name: |  |
| Relationship to resident: |  |
| Tel: |  |

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| 1. **Medical Aid Details:** | |
| Medical Aid Name: |  |
| Main Member’s Name: |  |
| Membership Number: |  |
| Copy of medical aid card must be included: | |

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| 1. **Medical Information: (Where applicable)** | |
| General Practitioner: | |
| Name: |  |
| Tel: |  |
| Psychiatrist: | |
| Name: |  |
| Tel: |  |
| Psychologist details: | |
| Name: |  |
| Tel: |  |
| Dentist details: | |
| Name: |  |
| Tel: |  |
| Other Specialist’s details: | |
| Name: |  |
| Tel: |  |

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| **Surgical Procedures Done:** |
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| **Medication:** | | | | | | | | |
| Is the applicant on regular/chronic medication? | | | | Yes | |  | No |  |
| Please complete Name, for which condition, and instructions below: | | | | | | | | |
| **Name** |  | **Dosage** | **Frequency** | | **Route** | | | |
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| **8.** | **DOES HE/SHE USE:** | | | | | |
| 12.1 | Dentures: | | Yes |  | No |  |
| 12.2 | Contact Lenses: | | Yes |  | No |  |
| 12.3 | Spectacles: | | Yes |  | No |  |
| 12.4 | Hearing Aid: | | Yes |  | No |  |
| 12.5 | Any other assistive devices: | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **9.** | **ALLERGIES:** | | | | | |
| Any known allergies? | | | | | | |
| Medication | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| Food | | Yes |  | No |  |
| If yes, please supply details: |  | | | | |
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| Other | | Yes |  | No |  |
| If yes, please supply details: |  | | | | |
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| **10.** | **EXERCISE:** | | | | | |
| Should exercise be restricted for any reason i.e. heart murmur, asthma)? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **11.** | **DAILY LIVING:** | | | | | |
| Any difficulties with daily living activities (i.e. bathing, dressing, toileting, shaving, etc.)? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **12.** | **EATING HABITS:** | | | | | |
| Has applicant got any difficulties, likes or dislikes? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **13.** | **WEIGHT:** | | | | | |
| Does weight need to be controlled? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **14.** | **ANY PROBLEMS WITH SLEEPING HABITS:** |
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| **15.** | **SEXUALITY:** | | | | |
|  | Females - menstruations: | Yes |  | No |  |
|  | Is applicant sexually aware? | Yes |  | No |  |
|  | Is applicant sexually active? | Yes |  | No |  |

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| **16.** | **PSYCHOLOGICAL CONDUCT (BEHAVIOUR):** | | | | | |
| Any mood swings? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| Are there any behavioural issues/incidents or dangerous behaviour that we need to be made aware of? | | | Yes |  | No |  |
| If yes, please supply details | |  | | | | |
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| **17.** | **APPLICANT’S CAPABILITIES:** | | | | |
| Is applicant able to look after Bedroom key? | | Yes |  | No |  |
| Is applicant able to look after Cupboard tidiness? | | Yes |  | No |  |
| Is applicant able to put out laundry for washing? | | Yes |  | No |  |

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| **18.** | **BASIC ACADEMIC ABILITY:** | | | | |
|  | Reading? | Yes |  | No |  |
|  | Writing? | Yes |  | No |  |
|  | Simple arithmetic? | Yes |  | No |  |

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| **19** | **INDEPENDENCE IN COMMUNITY:** | | | | | |
| Is applicant capable of: | | | | | | |
| Walking alone? | | | Yes |  | No |  |
| Going to corner shop to buy bread? | | | Yes |  | No |  |
| Shopping alone? | | | Yes |  | No |  |
| Telling the time? | | | Yes |  | No |  |
| Meeting at a pre-arranged time and place? | | | Yes |  | No |  |
| Other? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **20.** | **SWIMMING:** | | | | |
| Can applicant swim? | | Yes |  | No |  |
| Please details any special instructions: | | | | | |
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| **21.** | **HOBBIES, SPORTS, INTERESTS:** |
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| **22.** | **TEMPERAMENT (i.e. placid, shy, bossy, outgoing, aggressive): Please state triggers.** |
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| **23.** | **POCKET MONEY: Spending patterns – what would it probably be spent on?** |
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| **24.** | **EXTERNAL VISITORS:** | |
| Please supply us with names of approved visitors or friends who may visit on-site or take your family member out at agreed times. | | |
| Name: | |  |
| Tel: | |  |
| Name: | |  |

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| Tel: |  |
| Name: |  |
| Tel: |  |
| Name: |  |
| Tel: |  |

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| **25.** | **HOW WOULD YOU LIKE DOCTORS’/DENTISTS VISITS TO BE ARRANGED?** |
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| **26.** | **RELATIONSHIP DYNAMICS:** |
| Relationship with the following people are: | |
| Parents/Guardians | |
|  | |
| Siblings | |
|  | |
| Superiors | |
|  | |
| Peers | |
|  | |
| Girlfriend/Boyfriend | |
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| **27.** | **HOW DOES THE APPLICANT ADJUST TO CHANGE?** |
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| **32.** | **THERAPY SPECIALIST: ANY PREVIOUS THERAPY?** |
| 32.1 | Any previous therapy i.e. Physio/Occupational Therapy/Psychology etc.? |
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| 32.2 | Any current therapy? |
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| **33.** | **WHAT AREAS OF DEVELOPMENT WOULD YOU LIKE US TO FOCUS ON FOR YOUR FAMILY**  **MEMBER/RELATIVE?** |
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| **34.** | **WHAT SPECIAL TALENTS/SKILLS/ABILITIES DO YOU BELIEVE YOUR FAMILY MEMBER /**  **RELATIVE HAS THAT SHOULD BE DEVELOPED?** |
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| **35.** | **SICKNESS:** | | | | | |
| Is applicant prone to sickenss? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **36.** | **DOES HE/SHE WISH TO MOVE OUT OF YOUR HOME?** | | | | |
|  | | Yes |  | No |  |

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| **37.** | **IN YOUR OPINION, IS HE/SHE READY TO DO SO?** | | | | | |
|  | | | Yes |  | No |  |
| If no, please supply details: | |  | | | | |
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| **38.** | **HOW DO FAMILY MEMEBERS FEEL ABOUT THIS MOVE?** |
| 38.1 | Mother: |
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| 38.2 | Father: |
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| 38.3 | Siblings: |
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| 38.4 | Other: |
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| **39.** | **BEHAVIOURAL MODIFICATION: (ASK TONY)** |
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| **40.** | **ANY OTHER COMMENTS:** |
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| **PRE-ADMISSION CHECK LIST: Certified copies to be supplied of the following:** | | | |
| 1. | ID Document | Yes |  |
| 2. | Certified copy of medical aid card | Yes |  |
| 3. | Certified copies of medical reports | Yes |  |
| 4. | Neuro-psychologists report | Yes |  |
| 5. | Occupational therapist report | Yes |  |
| 6. | Psychologist/Psychiatrist report | Yes |  |
| 7. | Medical report | Yes |  |

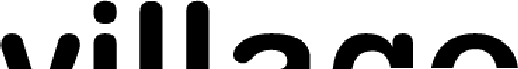
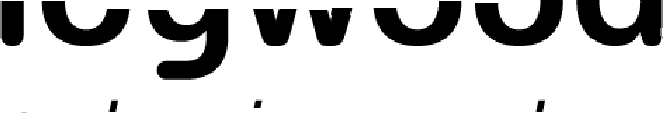
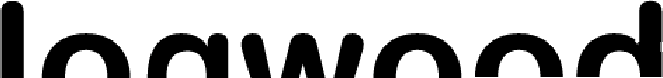
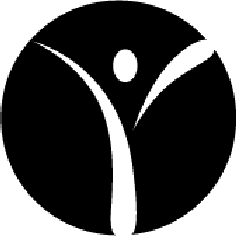
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| **OTHER DOCUMENTS TO BE SUPPLIED:** | | | |
| 8. | Trust details | Yes |  |
| 9. | Care reports from previous Residential Centres and shools | Yes |  |
| 10. | Any court orders in relation to maintenance of the applicant | Yes |  |

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| **FINAL PRE-ADMISSION DOCUMENTATION** | | | |
| 11. | Agreement form | Yes |  |
| 12. | Debit order form | Yes |  |
| 13. | Release form | Yes |  |
| ? | DG – prior to 15th days prior to the admission date, failure to do so would result in a R500-00 fine. | Yes |  |

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| **FOR OFFICE USE ONLY** |

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| 1. | Date of interview: |  | | | | |
| 2. | Conducted by: |  | | | | |
| 3. | Findings: |  | | | | |
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| 4. | Tour of Logwood: | | YES |  | NO |  |
| 5. | Application pack to be given to the family following the Interview: | | YES |  | NO |  |
| 6. | Has the applicant undergone a pre-admission screening & | | YES |  | NO |  |
|  | assessment? | |  |  |
|  | This entails the following:   * Neuro-psychology assessment * Occupational Therapist report * Psychiatrist report detailing primary & secondary diagnosis. Medical report to be completed by a General   Practitioner. | |  |  |  |  |
| 7. | Application pack to be returned to Logwood for the full | | YES |  | NO |  |
|  | admissions committee to review: | |  |  |
| 8. | Completion of the Logwood Village application form together with | | YES |  | NO |  |
|  | following attachments: | |  |  |
|  | - Reports and assessments referred to in pt 2.5 | | YES |  | NO |  |
|  | - Care reports from a previous residential facility or school | | YES |  | NO |  |
|  | - Certified copy of ID book to be handed in upon admission | | YES |  | NO |  |
|  | - Two ID/Passport size photos | | YES |  | NO |  |
|  | - Trust details – a copy of the trust deed for the prospective resident | | YES |  | NO |  |
|  | - Any court orders in terms of maintenance of the resident | | YES |  | NO |  |
|  | - Indemnity / Release forms: i.e. events that resident will be attending, haircuts, photographs, flu vaccinations, permission to go into Townships for sporting events, etc. | | YES |  | NO |  |

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|  | - Status of the disability grant to be verified and necessary documention finalized regarding the ceading of this grant to Logwood in order to cover a portion of the living costs of the individual being admitted | YES |  | NO |  |
|  | - Three references | YES |  | NO |  |
| - Original Doctors script must be handed in with application | YES |  | NO |  |
| - Letter of Acceptance to be prepared | YES |  | NO |  |
| - Final Interview with GM & RCM to confirm admission | YES |  | NO |  |
|  | - Agreement forms to be signed - with the understanding that provision will be made to ensure continued payment of fees | YES |  | NO |  |
|  | - Debit Order forms to be signed | YES |  | NO |  |
|  | - All information regarding in-appropriate, disturbing or  potential dangerous behavoiur to self or others must be disclosed | YES |  | NO |  |



**MEDICAL HISTORY QUESTIONNAIRE**

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| **1.** | **INOCULATIONS** | | | | |
| 1.1 | MMR – Measles | Yes |  | No |  |
| 1.2 | DPT – Tetanus | Yes |  | No |  |
| 1.3 | Havrix – Hepatitis A | Yes |  | No |  |
| 1.4 | Engerix B – Hapatitis B | Yes |  | No |  |
| 1.5 | Imovax Meningo – Meningitis | Yes |  | No |  |
| 1.6 | Polio Vac – Polio | Yes |  | No |  |
| 1.7 | Pneumovac – Phneumonia | Yes |  | No |  |
| 1.8 | BCC – Tuberculosis | Yes |  | No |  |
| 1.9 | MMR – Mumps | Yes |  | No |  |
| 1.10 | MMR – Rubella | Yes |  | No |  |
| 1.11 | DPT – Whooping Cough | Yes |  | No |  |
| 1.12 | DPT – Diphtheria | Yes |  | No |  |
| 1.13 | Last Tetanus Injection: | Yes |  | No |  |
| 1.14 | Last Chest X-Ray: | Yes |  | No |  |

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| **2.** | **GENERAL:** | | | | | |
| 2.1 | Are you aware of the reason for the Applicant’s Intellectual Disability? | | Yes |  | No |  |
| If yes, please state cause: | |  | | | | |
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|  | | | | |
| 2.2 | When was this condition first diagnosed and by whom (doctor, school, etc.)? | | | | | |
| Date: | |  | | | | |
| Doctor: | |  | | | | |
| School: | |  | | | | |

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| 2.3 | Is there any history of Intellectual Disability in the family (other than the Applicant)? | | Yes |  | No |  |
| If yes, what is the relationship to the Applicant? | |  | | | | |
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| **Please attach any medical report/documents supporting the diagnosis** | | | | | | |

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| **3.** | **ILLNESSES/ABNORMALITIES:** | | | | | |
| 3.1 | Does the applicant suffer from Epilepsy? | | Yes |  | No |  |
| 3.2 | What type of Epilepsy does he/she suffer from? |  | | | | |
| 3.3 | When was the first Epileptic seizure? |  | | | | |
| 3.4 | Who diagnosed the seizures as Epilepsy and when was this diagnosis made? |  | | | | |
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| 3.5 | How frequently do these seizures occur? |  | | | | |
| 3.6 | What was the date of the most recent seizure? |  | | | | |
| 3.7 | Name of Doctor currently treating the Applicant and date of last consultation regarding Epileptic seizures? |  | | | | |
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|  | | | | |
| 3.8 | Full details of the medication prescribed for these seizures? |  | | | | |
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| 3.9 | When was the last blood sample taken to determine the blood levels of medication used by the Applicant? |  | | | | |
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| 3.10 | Where and when was the last EEG done? |  | | | | |
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| **4.** | **OTHER NEUROLOGICAL CONDITIONS:** | | | | | |
| Are there any other brain conditions other than Epilepsy? | | | Yes |  | No |  |
| If no, please supply details: | |  | | | | |
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| **5.** | **RHEUMATIC FEVER:** | | | | | |
| Has the Applicant suffered from Rheumatic Fever? | | | Yes |  | No |  |
| If yes, did the Applicant develop any complications?  Specify details: | |  | | | | |
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| **6.** | **HEART CONDITIONS & BLOOD CIRCULATORY SYSTEM:** | | | | | |
| 6.1 | Does the Applicant have a heart problem? | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| 6.2 | Does the Applicant have other Blood Circulatory related problems: | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **7.** | **HYPERTENSION (HIGH BLOOD PRESSURE):** | | | | | |
| Does the Applicant suffer from Hypertension? | | | Yes |  | No |  |
| If so, please give the following details: | | | | | | |
| a | Name of Doctor currently treating the Applicant for this condition. |  | | | | |
| b | Date of last visit to this Doctor? |  | | | | |
| c | Full details of medication presently used for this condition? |  | | | | |

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| **8.** | **PORPHYRIA (Blistering & sores of the skin that heal with difficulty; skin sensitivity to**  **sunlight; very dark urine; constipation in conjunction with cramps)** | | | | | |
| Is the Applicant or any of his/her relatives a confirmed Porphyriac? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **9.** | **HEPATITIS (YELLOW JAUNDICE)** | | | | | |
| 9.1 | Does the Applicant suffer from Hepatitis? | | Yes |  | No |  |
| 9.2 | Type of Hepatitis? |  | | | | |
| 9.3 | When did the Applicant have this condition? |  | | | | |

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| **10.** | **THYROID ABNORMALITIES (GLOITERS)** | | | | | |
| Does the Applicant suffer from any Thyroid abnormalities? | | | Yes |  | No |  |
| If yes, please supply details: | |  | | | | |
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| **11.** | **RESPIRATORY SYSTEM PROBLEMS** | | | | | |
| Does the Applicant suffer from any of the following: | | | | | | |
| a | Asthma | | Yes |  | No |  |
| b | Proneness to Bronchitis/Pneumonia | | Yes |  | No |  |
| c | Any other Respiratory problems | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **12.** | **ABNORMALITIES OF THE URINARY SYSTEM** | | | | | |
| 12.1 | Is the Applicant able to maintain full bladder control? | | Yes |  | No |  |
| 12.2 | Is there any confirmed abnormality of the kidneys, bladder or urinary tubes? | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **13.** | **ABNORMALITIES OF THE DIGESTIVE SYSTEM** | | | | | |
| 13.1 | 1. Is the Applicant prone to constipation? | | Yes |  | No |  |
| 13.2 | 2. Is the Applicant able to maintain full bowel control? | | Yes |  | No |  |
| 13.3 | 3. Are there any problems relating to the Digestive System? | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **14.** | **SKIN CONDITIONS** | | | | | |
| Does the Applicant suffer from any of the following | | | | | | |
| a | Eczema | | Yes |  | No |  |
| b | Any other Skin Condition | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **15.** | **MUSCLE ABNORMALITIES** | | | | | |
| Does the Applicant suffer from any degenerative illness, abnormalities or any condition that affects the muscles of any part of the body? | | | Yes |  | No |  |
| If no, please supply details: | |  | | | | |
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| **16.** | **BONE ABNORMALITIES** | | | | | |
| Does the Applicant suffer from the following: | | | | | | |
| a | Inherited Bone Disease? | | Yes |  | No |  |
| b | Bone Abnormality due to injury? | | Yes |  | No |  |
| If you answered yes to | |  | | | | |

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| any of the above, please supply details: |  |
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| **17.** | **DIABETES** | | | | | |
| 17.1 | Does the Applicant suffer from Diabetes? | | Yes |  | No |  |
| 17.2 | Is there Diabetes in the family? | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **18.** | **TENDENCY TOWARDS ABNORMAL BLEEDING** | | | | | |
| Does the Applicant have a tendency towards excessive bleeding during surgery or injury? | | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **19.** | **ALLERGIES** | | | | | |
| Does the Applicant have allergies to any of the following? | | | | | | |
| a | Medicine | | Yes |  | No |  |
| b | Food | |  |  |  |  |
| c | Any other Allergies | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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|  | **20.** | **CORTISONE** | | | | |  |
|  | Has the Applicant ever used any Cortisone treatment? | | Yes |  | No |  |  |

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| If you answered yes to any of the above, please supply details: |  |
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| **21.** | **PAIN THRESHOLD** | | | | |
|  | | Yes |  | No |  |

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| **22.** | **STERILISATION/BIRTH CONTROL** | | | | | | |
| 22.1 | Has the Applicant been sterilised? | | Yes | |  | No |  |
| If yes, indicate the means of sterilization: | | | | | | | |
| a | Hysterectomy (Female Applicant) | | Yes | |  | No |  |
| b | Tying of Ovarian Tubes (Female Applicant) | | Yes | |  | No |  |
| c | Vasectomy (Male Applicant) | | Yes | |  | No |  |
| 22.2 | If the Applicant has not been sterilized, is he/she using any form of contraception? | | Yes | |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | | |
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| **NB! It is a condition that Female Applicants must be on a contraceptive should they be admitted.** | | | | | | | |
| In the case of a Female Applicant, please give the date of her last normal menstruation. | | | |  | | | |

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| **23.** | **SURGERY** | | | | | | | |
| 23.1 | Has the Applicant had any operations? | | | Yes | |  | No |  |
| 23.2 | List operations and give dates when surgery was performed: | | | | | | | |
| a |  | | **Date** | |  | | | |
| b |  | | **Date** | |  | | | |
| c |  | | **Date** | |  | | | |
| 23.3 | Did the Applicant have any breathing problems relating to the anesthetic whilst undergoing the above surgery? | | | Yes | |  | No |  |
| If you answered yes to | |  | | | | | | |

Please give date of last appointment.

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| any of the above, please supply details: |  |
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| **24.** | **MEDICAL AIDS/SUPPORT** | | | | | |
| Does the Applicant wear: | | | | | | |
| a | Spectacles (glasses) | | Yes |  | No |  |
| b | Dentures | | Yes |  | No |  |
| c | Hearing Aid | | Yes |  | No |  |
| d | Built-in Shoes | | Yes |  | No |  |
| e | Any Prostheses (artificial body parts) | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **25.** | **MENTAL STATE/CONDITION** | | | | | |
| 25.1 | Has the Applicant in the past, or does he/she at present suffer from any confirmed mental illness? | | Yes |  | No |  |
| 25.2 | Does the Applicant have any behavioral problems? | | Yes |  | No |  |
| 25.3 | Has the Applicant, or is he/she at present receiving any treatment/therapy of any behavioral problems (i.e. bed wetting,  soiling, temper tantrums etc.) | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| 25.4 | Does the Applicant at present display any behavior of concern (i.e.  change in appetite, insomnia, self inflicted injury, suicidal tendencies, hearing voices, etc.) | | Yes |  | No |  |
| If you answered yes to any of the above, please supply details: | |  | | | | |
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| **26.** | **DOCTOR’S DETAILS:** | |
| Name: | |  |
| Tel: | |  |
| Emergency tel number: | |  |
| Doctor’s recommendation (recommended treatments, lifestyle factors, etc.) | | |
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| **27.** | **DOCTOR’S SIGN-OFF:** | |
| Name: | |  |
| Signature: | |  |
| Date: | |  |

SIGNED at on this \_ day of 20\_ \_.

NAME:

DATE:

SIGNATURE:

RELATIONSHIP TO APPLICANT:

**New Admissions**

**Financial Interview Checklist**

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| **1.** | **PERSONAL INFORMATION** | | | | | | |
| Name of responsible parent / Family Member /Guardian | |  | | | | | |
| Name of Applicant | |  | | | | | |
| Contact details | |  | | | | | |
| Date of Application | |  | | | | | |
| 2.DOCUMENTATION: | | | YES: | | NO: | | |
| Id Document | | |  | |  | | |
| Proof of Residence | | |  | |  | | |
| Work address | | |  | |  | | |
| Proof of Income | | |  | |  | | |
| 3 Months’ Bank Statements | | |  | |  | | |
| Parents Agreement | | |  | |  | | |
| Debit order form | | |  | |  | | |
| Disability grant | | |  | |  | | |
| SASSA No | | |  | |  | | |
| Logwood Expectations | | |  | |  | | |
| **3. FEES** | | | | | | | |
| **How will fees be paid** | | | Monthly in advance | Yes | | No |
| Monthly Fees: R | | | Debit order | Yes | | No |
| Initial Deposit: R | | | Annually in Advance | Yes | | No |
|  | | | Initial deposit to be paid on acceptance |  | |  |
| 4. What provision has the family made for the care of the resident in future | | | | | | | |
| Trust fund | | | If yes please provide details |  | | |
| Surety | | | If yes please provide details |  | | |
| Life policies | | | If yes please provide details |  | | |
| Funeral Policy | | | If yes please provide details |  | | |
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