THE SALVATION ARMY
SOUTHERN AFRICA TERRITORY
HESKETH KING TREATMENT CENTRE

Application Form for Medical Aid and Private Patients
(Confidential)

Please note:

i. This form needs to be completed **FULLY** by a registered social service provider. **PLEASE NOTE: ALL SECTIONS NEED TO BE COMPLETED IN FULL.**
ii. **ALL PSYCHIATRIC AND MEDICAL REPORTS, A COPY OF ID DOCUMENT, COPY OF MEDICAL AID CARD (FRONT AND BACK) AND PARENT/GUARDIAN/PATIENTS CONTRACT** need to accompany the application form, **if not the application will be considered incomplete.**
iii. The accurate completion of this form is important in order to work effectively with applicant.
iv. This document is ethically binding and therefore all questions needs to be answered honestly.
v. All information supplied is treated in the strictest confidentiality.
vi. NO SMOKING ALLOWED IN THE SEVEN WEEK YOUTH PROGRAMME
vii. The Patient Contribution Fee (R600) will go towards administration
viii. Should medical aid decline payment or only partial payment is approved the patient/family will be liable for full payment
ix. Should a patient abscond or refuse treatment full payment will still be due

Program Selection

- ☐ **Seven-week inpatient treatment: Youth (16-20 years)**
- ☐ **Six-week inpatient treatment: Adult (21+)**
- ☐ **Twelve-week inpatient treatment: Adult (21+)**

Treatment Application Type

- ☐ **Medical Aid Application**
- ☐ **Private Patient Application**

IDENTIFYING DETAILS OF THE APPLICANT

Full Names: _____
Date of Birth/ID Number: _____
Residential Address: _____
Telephone: _____
Faith/Church: _____

IDENTIFYING DETAILS OF THE PARENTS/GUARDIAN

Biological Father/ Guardian
Name and Surname: _____ **Age:** _____
Telephone: _____

Biological Mother/ Guardian
Name and Surname: _____ **Age:** _____
Telephone: _____

Siblings

Name and Surname: _____ **Age:** _____
Name and Surname: _____ **Age:** _____
Name and Surname: _____ **Age:** _____
Name and Surname: _____ **Age:** _____
Name and Surname: _____ **Age:** _____

Caregiver/Foster Parent

Name and Surname: _____ **Age:** _____
Telephone: _____

FAMILY HISTORY AND RELATIONSHIPS

Describe briefly the relationships between family members before active addiction:

_____

_____

_____

Describe briefly the relationships between family members after active addiction:

_____

_____

_____

Describe briefly the socio-economic circumstances of the family:

Housing (Wendy, own house, separate entrance, rooms, etc):

_____

_____

Environment (General issues, problems of the area):

_____

_____

Income of the family (How is the family financially supported):

_____

_____

Development of the person (Please mark where applicable):

Age	Normal	Problematic
0-5 yrs		
6-11yrs		
12-20 yrs		
20-30 yrs		
30-40 yrs		

40-50 yrs		
50-60 yrs		
60+ yrs		

Describe all developmental problems other than addiction (example. Hospitalization as a child or young child):

_____

_____

_____

<u>Other important relationships</u> (peers, persons in his own age group):

_____

_____

_____

EDUCATION

Name of current/last school attended: _____

Current Grade: _____

Highest Grade Passed: _____

Progress in school: _____

_____

Disciplinary history: _____

Date of Leaving School: _____

Reason for leaving school: _____

EMPLOYMENT HISTORY

(Include casual jobs)

Company	Position held	Reason for leaving

MEDICAL HISTORY

HOSPITALIZATION

Date when Hospitalized: _____

Reason for Hospitalization: _____

Duration of Hospitalization: _____

Operations: _____

Serious Injuries: _____

Chronic Illnesses: _____

Medication: _____

PSYCHIATRIC HISTORY

Date when Hospitalized: _____

Reason for Hospitalization: _____

Duration of Hospitalization: _____

Psychiatrist: _____

Diagnoses: _____

Hallucinations: _____

_____

(Hallucinations is hearing and seeing things that others do not hear or see)

Medication: _____

Suicidal thoughts: _____

ADDICTION HISTORY

Drug of choice: _____

Age of first usage: _____

Substance Use History:

	Drug of choice			
	1st Choice	**2nd Choice**	**3rd choice**	**Name drug** (example Dagga)
Inhalant				
Drug				
Alcohol				
Cigarettes				
Other				

Quantity of use:

_____

_____

Frequency, setting (alone, at home, with friends):

_____

_____

Methods used to obtain and administer the drugs:

_____

_____

_____

PREVIOUS TREATMENT

In- Patient Treatment

Name of the Institution(s): _____

_____

_____

Period(s)/for how long: _____

_____

Reason, if treatment was not completed: _____

_____

Out-patient

Name of the Institution(s): _____

_____

Period(s)/for how long: _____

_____

_____

Reason, if treatment was not completed: _____

_____

<u>Current treatment:</u>

Motivation for current treatment:

_____

_____

_____

_____

CRIMINAL OFFENCES

Pending Cases: _____

Nature Of offence: _____

All previous convictions: _____

<u>Probation Officer Details</u>

Name and Surname: _____

Contact number: _____

Designated Court: _____

GANG INVOLVEMENT

Please tick the appropriate block		
<u>Involvement</u>	**<u>Tick</u>**	**<u>Provide Details</u>** **(What type of gang and for how long)**
I am involved in a gang		
I Am no longer involved in a gang		
I am not a gangster, I just moved with the gang		

CHILD CARE ACT INTERVENTION (if applicable)

Welfare intervention (YES/NO): _____

Welfare organization: _____

Type of intervention: _____

Details of Welfare Organization: _____

Other relevant information: _____

_____

_____

AFTERCARE

Organization: _____

Aftercare Worker: _____

<u>Contact Details</u>

Physical Address: _____

Telephone number: _____

Email: _____

COST OF TREATMENT

There are various treatment options for medical aid and private patients. The youth program consists of a seven-week program for young males between the ages of 16 and 20, at the cost of R20 000

The adult program offers two different programs for men who are older than 21. There are the six-week program for R20 000 and a twelve-week program for R30 000.

All private paying patients should complete the "Acknowledgement of Debt" form and submit it with this application form.

AGREEMENT BY PATIENT

I, _____ (name of potential patient) undertake to give my full cooperation during the program.

_____	_____	_____
Name of Patient	**Signature**	**Date**
_____	_____	_____
Name of Social Worker/S.Aux Worker	**Signature**	**Date**

<u>Information of Compiler of Application form:</u>

Organization: _____

Address: _____

Telephone number: _____

E-mail address: _____