APPLICATION FORM
NURSING CARE BENEFITS

PLEASE NOTE: Sub-acute facilities/alternatives to hospitalisation are subject to pre-authorisation.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number

Benefit option ☐ Network Option ☐ Saver Option ☐ Comprehensive Option

Title | Initials | ID number

Full name and surname

Email address

PATIENT DETAILS

Dependant code

Title | Initials | ID number

Full name and surname

Contact numbers | Home | Work

Cell phone

Kindly indicate your preferred day and time for contact (Mon - Fri 9:00 - 16:00)

Postal address

Postal code

Email address

PATIENT CONSENT

I understand that Wooltru Healthcare Fund and Momentum Health Solutions, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration for nursing care benefits.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.
- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.

Membership number | Doctor's practice number

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Wooltru Healthcare Fund has appointed Momentum Health Solutions (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Fund, Momentum Health Solutions and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions and its employees or the Fund and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/ guardian if patient is under the age of 18)

Date
DD/MM/YYYY

2. MEDICAL PRACTITIONERS' INFORMATION

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

HEALTHCARE PROVIDER DETAILS

Practice number

Initials

Speciality

Surname

Contact numbers

Work

Fax

Cell phone

Postal address

Postal code

Email address

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONERS' INFORMATION (CONTINUED)

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER (CONTINUED)

GENERAL PRACTITIONER DETAILS

Practice number

Initials

Surname

Contact numbers | Work | Fax

Cell phone

Postal address

Postal code

Email address

NURSING AGENCY DETAILS

Practice number | Contact number

Agency name

Email address

REGISTERED NURSE DETAILS

Practice number | Contact number

Full name and surname

Email address

3. CLINICAL EXAMINATION

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

Period for which nursing service is required:

From (DD/MM/YYYY) to (DD/MM/YYYY)

DETAILS OF DIAGNOSIS

Diagnosis	ICD-10 code(s)	Tariff code(s)

If your patient is at risk of being HIV positive, or has been diagnosed as a person living with HIV/AIDS, please advise them to register on the HIV **YourLife** Programme on 0860 109 793 (all calls are confidential).

Membership number | Doctor's practice number

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER (CONTINUED)

GENERAL CARE REQUIREMENTS

Number of hours of care required per day:

Registered nurse		hours
Assistant nurse		hours
Staff nurse		hours
Care worker		hours

Please define the role of each of these nurses, as they relate to the number of hours of care required:

PERSONAL CARE STATUS

Feeding	☐ Independent	☐ Minimal assistance	☐ Must be fed	
Toilet use	☐ Independent	☐ Minimal assistance	☐ Bladder incontinence	☐ Bowel incontinence
Bathing	☐ Supervision	☐ Must be bathed	☐ Assistance in/out of the bath	
Dressing and grooming	☐ Independent	☐ Needs assistance	☐ Supervision only	

General comments

MENTAL HEALTH STATUS

Need for restraint	☐ Frequently	☐ Occasionally	☐ Always	☐ Never
Wandering	☐ Frequently	☐ Occasionally	☐ Always	☐ Never
Behaviour – disorientated	☐ Frequently	☐ Occasionally	☐ Always	☐ Never
Behaviour – impaired judgement	☐ Frequently	☐ Occasionally	☐ Always	☐ Never

General comments

Membership number

Doctor's practice number

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER (CONTINUED)

AMBULATION STATUS

Ambulation
- ☐ Independent
- ☐ Independent with device
- ☐ Aid of one person
- ☐ Aid of two people
- ☐ Unable (bedridden)

Transferring and positioning
- ☐ Independent
- ☐ Independent with device
- ☐ Aid of one person
- ☐ Aid of two people
- ☐ Unable

General comments

SENSORY STATUS

Vision
- ☐ Normal
- ☐ Partial impairment
- ☐ Unable

Hearing
- ☐ Normal
- ☐ Partial impairment
- ☐ Unable

Communication
- ☐ Normal speech
- ☐ Speech impairment
- ☐ Inappropriate content
- ☐ Makes needs known with difficulty
- ☐ Unable to speak

General comments

OTHER

Pain management
- ☐ None required
- ☐ Some management
- ☐ Moderate management
- ☐ Difficult to manage

Perceptual motor function
- ☐ Normal
- ☐ Partial impairment
- ☐ Unable

Compliance with treatment regime
- ☐ None
- ☐ Occasionally
- ☐ Frequently
- ☐ Always

Family/social support
- ☐ None
- ☐ Occasionally
- ☐ Frequently
- ☐ Always

General comments

Is the patient registered on the Chronic Medication Risk Management Programme for chronic medication? ☐ Yes ☐ No

4. MEDICATION AND TREATMENT

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

MEDICATION

Name of medication	**Frequency** (how often is this medication taken?)	Dosage

Membership number _____ Doctor's practice number _____

4. MEDICATION AND TREATMENT (CONTINUED)

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER (CONTINUED)

MEDICATION (CONTINUED)

Name of medication	**Frequency** (how often is this medication taken?)	Dosage

TREATMENT AND THERAPIES

Treatment	Frequency
Inhalation treatment	
Suctioning	
Tracheostomy care	
Vital signs	
Indwelling catheter	
Intravenous therapy	
Stoma care	
Tube feeding	
Intake and output	
Wound care (please provide details)	
Other treatment recommended (not mentioned above)	

Comments

Membership number

Doctor's practice number

5. ADDITIONAL NURSING CARE NEEDS

TO BE COMPLETED BY A REGISTERED NURSE OR HEALTHCARE PROVIDER

Please specify if there are any additional nursing care needs required that haven't already been covered by the sections above:

Referring doctor's signature

Date

DD/MM/YYYY

Membership number

Doctor's practice number

07/2022