HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

Application Form 1

To be completed by Medical Practitioner

Patient's Name : _____

Doctor, or Hospital Report : _____

Contact Details : Landline : _____

Cell No's.: _____

I hereby confirm that this patient is a suitable candidate for consideration for financial assistance and complies with the following criteria:

1) The patient is a permanent resident of the magisterial district of Umgeni Municipality. ☐
2) The patient has a medical condition which requires the following treatment. ☐
   a. Nature of complaint: _____
   _____
   _____
   b. Recommended treatment: _____
   _____
   _____
3) The patient does not have access to sufficient funds to pay for this treatment. ☐
4) The patient has attended an appointment at an approved Government Health facility (Greys, Edendale, and Northdale) ☐
5) An estimated time to treatment at government health facility Time estimated _____
6) The treatment will provide lasting improvement to the health of the patient. ☐
7) The recommended treatment will be effective and beneficial to the patient. ☐

Confirmed by : _____ Date : _____

Medical Practitioner / Hospital Authority

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

ESTIMATION OF FINACIAL COSTS OF DEFINITIVE MEDICAL ASSISTANCE

COMPLETED BY TREATING DOCTOR / SURGEON

To be completed by Medical Practitioner application form 2

Patient: _____

Doctor:_____

RECOMMENDED DATE FOR TREATMENT: _____

RECOMMENDED VENUE FOR TREATMENT:_____

Description of treatment / procedure	RATES
Medical Practitioner:	
Hospital estimate :	
Prosthesis:	
Specialists Estimate :	
Anaesthetist Estimate:	
Other costs: ie: ambulance, wheelchair, crutches	
	TOTAL COST:

_____

Treating Medical Practitioner

_____

Date

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

APPLICATION FORM FOR FINANCIAL ASSISTANCE FOR MEDICAL CARE

Application Form 3

PERSONAL DETAILS FORM
To be completed by applicant

Full Name of Patient : _____

Identity Number : _____ Age : _____ Years

Residential Address : _____
Physical (**Not PO Box No.**)

_____

_____

_____

How long have you been a resident of the Natal Midlands : _____

Contact Details : Landline (home) : _____

Landline (office) : _____

Cell No's. : _____

Next of Kin : _____

Relationship : _____

Contact Details : _____

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

CURRENT MEDICAL AND FINANCIAL STATUS

Application Form 4

To be completed by Applicant

1. Are you a member of a medical aid society? Yes ☐ No. ☐

2. If yes, please provide the full details of medical status

   a) Name of Medical Aid _____

   b) Membership number _____

3. Are you registered as a tax payer with SARS? Yes ☐ No. ☐

4. If yes, please provide a copy of your latest income tax assessment.

5. Are you currently employed? Yes ☐ No. ☐

6. If yes, name of employer _____

   Current monthly income _____

   Value of fringe benefits _____

7. If no, when were you last employed _____

Name of previous employer _____

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

FINANCIAL POSITION
INCOME

To be completed by Applicant
Form 5

Name of patient _____
Financial Statement _____

INCOME	Reference Number Where applicable	Monthly Income Self	Spouse
Salary			
Pension			
Retirement or purchased annuities			
Income from a trust Dividends Interest Capital gains			
Investments Dividends received Interest			
Financial Institutions			
Rental Received			
Capital Gains received Property Investments Unit Trusts			
Offshore investments Income Capital gains			
Total Monthly income			

Certified correct.

_____ Date : _____

Applicant

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

FINANCIAL POSITION
EXPENSES

To be completed by Applicant
Form 6

Name of patient _____
Financial Statement_____

Committed Expenditure (Monthly)	**Reference number Where applicable**	**Self**	**Spouse**
Deductions from monthly income Income tax Pension Medical aid			
Bond Instalment			
Vehicle HP			
School fees Name of school _____ No of Children			
Electricity /rates			
Household expenses monthly			
Other commitments			
Total Monthly expenses			

Certified correct.

_____ Date : _____

Applicant

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

FINANCIAL POSITION
ASSETS / LIABILITIES

To be completed by Applicant
Form 7

Name of patient _____
Financial Statement_____

ASSETS	Reference Number Where applicable	Self	Spouse
Residence, estimated market value			
Less mortgage bond held by:			
Other property			
Listed investments at market value			
Offshore investments at market value			
Financial Institutions			
Motor vehicle, value Type_____ Year_____ HP Contract			
Last 5 years Assets sold specific			
Value of assets donated			
Cash donated			
Total Monthly expenses			

Certified correct.

_____ Date : _____

Applicant

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

INTERNAL ASSESSMENT FORM

To be completed by HCMCT Committee

Application Form 8

CASE NO.:

DOCUMENTS SUBMITTED:

1. Certified Copy of Identity Document ☐
2. Latest Income Tax Assessment ☐
3. Personal Balance Sheet ☐
4. Salary Slip ☐
5. Affidavit / proof of consultation at government hospital ☐

Committee's Comments:

_____

_____

_____

_____

_____

Recommendation by Committee:

A. Financial assistance offered to a maximum value of R.....

B. Application Rejected ☐

Signed By : _____ Date : _____
Medical Sub-Committee

Signed By : _____ Date : _____
HCMCT Chairman

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

OFFER OF FINANCIAL ASSISTANCE BY THE HCMCT
&
ACCEPTANCE OF OFFER BY PATIENT

Application Form 9

CASE NO.:

1) The Trust will only pay for treatment in hospital.

i) All pre op and post-operative out of hospital costs to be covered by the applicant (to be discussed with treating doctor before treatment)

2) The Trust will only make payment directly to the providers of medical care.

3) The Trust will not pay the patient directly to cover the costs of approved medical care.

4) The Trustees have considered this application, confirm that financial assistance will be offered to the patient, up to a maximum of R……..

INDEMNITY

The Trustees of the Howick Community Medical Charitable Trust only offer to make financial assistance available to the patient.

The patient hereby confirms that, although he or she is the recipient of financial assistance, that the choice of medical care is the sole responsibility of the patient. The Trustees cannot be held responsible for, nor offer any assurance of satisfactory treatment for, any aspect of medical care provided to the patient by either a medical practitioner, or by any hospital, clinic, ambulance or emergency service (or any employee thereof) if the medical service provided is in any way unsatisfactory, defective or negligent.

The patient acknowledges the duration of this approved application and quote is limited to …… months, date ending ……., in which the medical procedure is to take place. Failing the stipulated period, then this offer of financial assistance will lapse and the patient would be required to reapply.

Trustee 1 : _____ Date :_____

Trustee 2 : _____ Date :_____

The above Terms and Conditions are accepted by:

Applicant : _____ Date :_____

HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

PAYMENT AUTHORISED BY MEDICAL SUB-COMMITTEE

Application Form 10

CASE NO.:

Name of Patient : _____

Date Authorised by Medical Committee for Treatment : _____

Type of Procedure : _____

_____

Hospital Used

Howick	Hilton Life	other

Pre Invoice Attached :

YES	NO

Name of Doctor(s) : _____

_____

Others Medical Costs : _____

_____

_____

APPROVED BY : _____ Date : _____

Member of Medical Sub-Committee