Howick Community Medical Charitable Trust

IT Reg: 1626/2007/PMB

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HOWICK COMMUNITY MEDICAL CHARITABLE TRUST

Please complete this form as clearly as possible. If you need help, ask a family member, friend, or community worker to assist you.

PATIENT DETAILS

- Full Name: _____
- ID Number: _____ Age: _____
- Physical Address: _____
  _____Postal code: _____
- Phone Number: _____Cell phone number_____
- Email Address_____
- How long have you lived in the Umgeni area? _____
- Next of Kin: Name _____ Contact number _____

MEDICAL INFORMATION

- What medical treatment do you need? _____
  _____
  _____
- Which hospital/clinic recommended this treatment?
  _____
  _____
- Have you been to a government hospital first? ☐ Yes ☐ No
- Doctor's/Clinic name: _____

WORK AND INCOME

- Are you currently working? ☐ Yes ☐ No
- If yes, where do you work? _____
- How much money do you earn per month? R_____
- If not working, when did you last work? _____
- Do you receive any grants or pensions? ☐ Yes ☐ No
- If yes, how much per month? R_____
- Does anyone else in your household work? ☐ Yes ☐ No
- If yes, how much do they earn per month? R_____

HOUSEHOLD INFORMATION

- How many people live in your house? _____
- How many are children under 18? _____
- Are you the main person supporting the family? ☐ Yes ☐ No

MONTHLY EXPENSES (approximately)

- Rent/bond payment: R_____
- Electricity: R_____
- Food: R_____
- Transport: R_____
- School fees: R_____
- Other expenses: R_____
- **TOTAL** monthly expenses: R_____

ASSETS (what you own)

- Do you own your house? ☐ Yes ☐ No
- If yes, estimated value: R_____
- Do you own a car? ☐ Yes ☐ No
- If yes, estimated value: R_____
- Do you have savings in the bank? ☐ Yes ☐ No
- If yes, how much? R_____

- Do you have other investments? ☐ Yes ☐ No
- If yes, what is the value? R_____
- Do you have medical aid? ☐ Yes ☐ No

DECLARATION

I confirm that:
• I am a resident of the Umgeni Municipality area
• I cannot afford to pay for this medical treatment
• All information provided is true and correct
• I am not a member of a medical aid/insurance scheme
• I understand the Trust will only pay the hospital directly, not me
• If I provided false information, the Trust can ask me to pay back the money

Patient/Applicant Signature: _____

Date: _____

DOCUMENTS TO ATTACH:

☐ Copy of ID document

☐ Proof of income (payslip or grant letter)

☐ Letter from doctor/hospital about treatment needed

☐ Proof of address

For Office Use Only:

Case Number: _____ Date Received: _____

Committee Decision: ☐ Approved ☐ Declined
Amount Approved: R_____