



health

Department of
Health
FREE STATE PROVINCE

ANNEXURE A

DEPARTMENT OF HEALTH: PROVINCE OF THE FREE STATE

APPLICATION FOR A LICENCE AS A PRIVATE HEALTH ESTABLISHMENT IN TERMS OF REGULATION XXX OF XXX

THE HEAD OF DEPARTMENT
PO BOX 227
BLOEMFONTEIN
9300

Application is hereby made for a licence for the following private health establishment, details of which are supplied below for the year ending 31 December 20.....

FORM 1

PART A

APPLICATIONS FOR NEW ACUTE AND NON - ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section is compulsory and must be completed by all applicants)

1. Name of proposed private health establishment

2. In which area will the private health establishment be built (Town and Suburb)?

3. Has the site already been acquired for the said establishment (Provide Erf Number)?
If a site has not been acquired, full details of the site must be provided to the Department immediately when such a site is acquired.

4. Will there be any other buildings and/or activities on the site other than the proposed private health establishment? If so, provide details.

5. PPP Venture

Is the applicant willing to enter into partnership with the Department for future ventures?

6. List of Board of Directors and B-BBEE status

7. Provide applicable details of applicant.

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

8. How many other private health establishment licences do you or CC's/Trusts to whom you are affiliated hold nationally? Provide details of other licensed establishment, such as (a) when the licence was granted, (b) when the license expires, (c) composition of licenses e.g. number of beds and theatres etc., (d) location.

(Use separate sheet if necessary)

9. Name, address and contact details of developer.

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

10. Registration number of company or close corporation.

11. Name, address and contact details of service provider (if different to applicant).

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

12. What are the clinical disciplines to be practised in the proposed establishment?

(Use separate sheet if necessary)

PART B

NEW ACUTE PRIVATE HEALTH ESTABLISHMENTS (This section must only be completed by applicants applying for an Acute Establishment Licenses)

13. Number of beds/treatment stations applied for:

Adult:	i). ii). iii).	Medical Surgical Day	_____ _____ _____
Maternity:	i). ii).	Obstetrics Babies	_____ _____
Intensive care:	i). ii). iii)	Adult Pediatric Neonatal	_____ _____ _____
High Care:	i). ii). iii)	Adult Pediatric Neonatal	_____ _____ _____
Paediatric	i). ii). iii).	Medical Surgical Day	_____ _____ _____
Isolation beds:	i). ii). iii)	Adult Pediatric Neonatal	_____ _____ _____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

14. Number of theatres/treatment rooms applied for:

Minor theatre	_____
Major theatre	_____
Cardiac Theatre	_____
Cardiac Catheterization Laboratory	_____
General Procedure room/s	_____

First stage rooms _____

Delivery rooms _____

**Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc)**

Unit Name:

(1) _____ Room Name: _____ Total: _____

(2) _____ Room Name: _____ Total: _____

(3) _____ Room Name: _____ Total: _____

(4) _____ Room Name: _____ Total: _____

(5) _____ Room Name: _____ Total: _____

(6) _____ Room Name: _____ Total: _____

(7) _____ Room Name: _____ Total: _____

(8) _____ Room Name: _____ Total: _____

(9) _____ Room Name: _____ Total: _____

(10) _____ Room Name: _____ Total: _____

15. Number of medical staff to be employed.

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

16. Number of nursing staff employed.

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

17. Other full-time registered staff employed. If any, specify.

18. Other part-time registered staff employed. If any, specify.

19. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc)

20. Supplementary health services personnel

- i). Administrative personnel _____
- ii). Management _____
- iii). General assistant/s _____
- iv). Maintenance staff _____

21. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

22. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

23. Provide detailed reasons in accordance with the criteria as set out in 9(2)(a) to (n) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

24. Any other information deemed necessary for this application.

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

Signature

PART C

NEW NON-ACUTE PRIVATE HEALTH ESTABLISHMENTS
(This section must only be completed by applicants applying for a Non-Acute Establishment License)

25. State what type of establishment is applied for (i.e. step-down, sub-acute, rehabilitation, long-term, hospice, convalescent)

26. Do you belong to a quality assurance group? If so, provide details.

27. Do you have any managed care or similar arrangement with any health funder/employer?

28. Number of beds/treatment stations applied for:

Adult:	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____

Paediatric	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____

Other Specialized Beds: _____

TOTAL BEDS APPLIED FOR _____

29. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

30. Will you provide any outpatient services?

31. Number of medical staff to be employed.

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

32. Number of nursing staff employed

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

33. Other full-time registered staff employed. If any, specify.

34. Other part-time registered staff employed. If any, specify.

35. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc.)

36. Supplementary health services personnel

- i). Administrative personnel _____
- ii). Management _____
- iii). General assistant/s _____
- iv). Maintenance staff _____

37. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

38. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

39. Provide detailed reasons in accordance with the criteria as set out in (9)(2)(a) to (n) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

40. Any other information deemed necessary for this application.

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

Signature

FORM 2

PART A

**APPLICATIONS FOR EXTENSIONS TO EXISTING ACUTE
PRIVATE HEALTH ESTABLISHMENTS**

(To be completed by applicants applying for an extension to their licensed private health establishment)

1. Name of private health establishment

2. Physical address

3. Erf no: _____

4. Provide applicable details of applicant.

Title: _____ Initials: _____ Surname: _____

Company: _____ Trust/CC: _____

Postal Address: _____

Office Phone: _____ Fax: _____

E-mail: _____ Emergency Phone: _____

5. Registration number of company or close corporation.

6. Applicable details of service provider

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

PART B

ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for an extension to an Acute Establishment License)

7. Attach a copy of the existing licenses certificate as an addendum to this application:

41. Number of beds/treatment stations applied for:

Type of beds, theatres, units, rooms	Existing services	New services	Variance
Adult medical beds			
Adult surgical beds			
Obstetric beds			
Adult ICU beds			
Neonatal ICU beds			
Adult High Care beds			
Pediatric beds			
Day beds			
TOTAL NUMBER OF BEDS			
Minor theatres			
Major theatres			
First stage rooms			
Delivery rooms			
Emergency units			
Resuscitation rooms			
Lazer units			
Cath labs			
Haemodialysis unit			
Procedure rooms			

8. Number of theatres/treatment rooms applied for:

- Minor theatre _____
- Major theatre _____
- Cardiac Theatre _____
- Cardiac Catheterization Laboratory _____
- General Procedure room/s _____
- First stage rooms _____
- Delivery rooms _____

**Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc.)**

Unit Name:

- | | | |
|------------|------------------|--------------|
| (1) _____ | Room Name: _____ | Total: _____ |
| (2) _____ | Room Name: _____ | Total: _____ |
| (3) _____ | Room Name: _____ | Total: _____ |
| (4) _____ | Room Name: _____ | Total: _____ |
| (5) _____ | Room Name: _____ | Total: _____ |
| (6) _____ | Room Name: _____ | Total: _____ |
| (7) _____ | Room Name: _____ | Total: _____ |
| (8) _____ | Room Name: _____ | Total: _____ |
| (9) _____ | Room Name: _____ | Total: _____ |
| (10) _____ | Room Name: _____ | Total: _____ |

9. Provide detailed reasons in accordance with the criteria as set out in (9)(2)(a) to (n) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

10. Have there been any structural and/or functional changes in patient accommodation during the current year?

(Use separate sheet if required and attach as addendum to this application)

11. Number of nursing staff employed at the date of application.

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

12. Number of medical practitioners employed at the time of application

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

13. Other existing full-time registered staff employed, if any specify.

14. Other part-time registered staff employed, if any specify.

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

Signature

PART C

NON- ACUTE EXISTING PRIVATE HEALTH ESTABLISHMENTS (This section must only be completed by applicants applying for extensions to Non-Acute Establishment Licenses)

15. State what **service you wish to extend** (i.e. step-down, sub-acute, rehabilitation, long-term, hospice, convalescent)

16. Do you belong to a quality assurance group? If so, provide details.

17. Do you have any managed care or similar arrangement with any health funder/employer?

18. Number of beds/treatment stations applied for:

Adult:	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____

Paediatric	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____

Other Specialized Beds: _____

TOTAL BEDS APPLIED FOR

19. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

19. Will you provide any outpatient services?

20. Number of medical staff to be employed.

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

22. Number of nursing staff employed

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

23. Other full-time registered staff employed. If any specify

24. Other part-time registered staff employed. If any specify

25. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc)

26. Supplementary health services personnel

- i). Administrative personnel
- ii). Management
- iii). General assistant/s
- iv). Maintenance staff

27. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

28. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

29. Provide detailed reasons in accordance with the criteria as set out in (9)(2)(a) to (n) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

30. What was the average bed occupancy rate and average length of stay for the previous calendar year?

31. What proportion (%) of patients were discharged from the establishment in the last calendar year?

- i). Less than one week _____
- ii). More than three days but less than one week _____
- iii). One to three months _____
- iv). More than three months _____
- v). No potential for discharge _____

32. What proportion (%) of admissions were re admissions within:

- (a) 3 months _____
- (b) 6 months _____
- (c) 1-year _____

33. What proportion (%) of patients admitted over the last calendar year were:

- i). Post-surgical (requiring traction, drainage, or wound care?) _____
- ii). Post-medical illness (e.g. stroke) or requiring low-grade medical interventions (rehydration, IV, antibiotics, oxygen) _____
- iii). Chronically disabled (mental, physical – e.g. Dementia, hemiplegic) _____
- iv). Terminally ill (end stage) _____
- v). For respite care _____
- vi). Other general rehabilitation _____
- vii). Patients admitted instead of acute hospitalisation for an acute illness, injury or exacerbation of a disease process _____

- viii). Patients requiring nursing care of low intensity who are likely to remain for a long period of time _____
 ix). Other _____

34. Of patients discharged over the last calendar year, what proportion (%) were discharged: (not to be filled in by hospices)

- i). Directly home _____
 ii). Other community-based facility _____
 iii). To a hospice _____
 (iv) Other _____

35. Number of full-time and part-time nurses at the establishment at the time of application.

Category of staff	No. of personnel	Full-time	Part-time
(a) Professional Nurse			
(b) ENA			
(c) Enrolled nurses			
(d) Care workers			

*Care workers are workers who deliver basic support and assistance and who assist with activities of daily living and who are not registered with the SANC.

36. Does the establishment provide services rendered by other professionals?

Mark F/T, P/T, SESSIONAL

Doctors (specify)	
Physiotherapists	
Occupational therapists	
Speech and hearing therapists	
X-Ray Services (specify)	
Arrangements for a laboratory services for pathology services (specify)	
Medical specialists (e.g. orthopaedic surgeon, psychiatrists)	
Social Worker	
Pharmacist	
Dietician	
Others (specify)	

37. On average how often are your patients assessed?
(Tick the most appropriate category)

Half hourly	
Hourly	
Between 1 and 4 hourly	
Between 4 and 8 hourly	
Between 8 and 24 hourly	
Once daily	
Between once daily and once weekly	
Less than once weekly	

38. Are the following treatments provided at the establishments?

Y/N

Oral antibiotics on prescription	
Intravenous medication	
Urinary catheterisation	
Blood pressure monitoring	
Oxygen supply and suction	
Ambubag	
Electrocardiograph	
Intubation	
Defibrillation	
Naso-gastric feeding	

39. Of your last 100 admissions, what % were referred by:

A private hospital	
A private medical practitioner	
A private practitioner other than a private medical practitioner	
A public hospital	
A residential facility such as an old age home	
A welfare institution other than a residential facility	
A traditional healer	
Directly by the family	
Referred by self	
Case manager (e.g. QA Care)	
Others (specify)	

40. Do you provide any out- patient services?

Place _____

Date _____

Office/Position held _____

Signature

CHECK-LIST OF DOCUMENTS THAT SHOULD BE SUBMITTED WITH THE APPLICATION FORMS

DOCUMENTS	TICKS
Motivational letter	
Proof of payment of application fee	
Proof that the applicant has advertised in the relevant local paper the intention to build the private facility	
Proof of community endorsement of the project	
A letter from the Municipality stating that the desired land has been granted and is suitable for the intended business	
Feasibility study	
Business Plan	
Proof of financial viability	
Human resource recruitment plan	
B-BBEE certificate and list of Directors	
Community Involvement/social responsibility plan	