

*Paying the right social grant, to the right person  
,at the right time and place. NJALO!*



**sassa**  
SOUTH AFRICAN SOCIAL SECURITY AGENCY

# **Functional/ Medical Assessment:** **Disability Grant**

## **Required documentation**

- Medical referral form
- ID Document
- Clinical / medical records

Clinical / medical records are always required except where the client has an obvious disabling condition for which they are not currently receiving treatment. Such clients are nonetheless expected to provide SASSA with a complete medical referral form and their ID document.

- GIA - Grant in Aid
- DG - Disability Grant
- CDG - Care Dependency Grant
- BP - Blood Pressure
- BMI - Body Mass Index

|          |    |
|----------|----|
| Ref No.: | DG |
|----------|----|



**FUNCTIONAL/ MEDICAL ASSESSMENT:  
DISABILITY GRANT**

*Instructions on filling this form: Please write legibly and in capital letters  
This form must not be handed over to Client  
Mark with X where appropriate*

**Part A: Client's Particulars (To be filled by SASSA Official)**

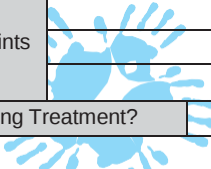
|                        |  |    |  |                                      |  |  |  |  |  |  |                               |                   |  |        |  |  |        |  |  |
|------------------------|--|----|--|--------------------------------------|--|--|--|--|--|--|-------------------------------|-------------------|--|--------|--|--|--------|--|--|
| Form of Identification |  | ID |  | Other methods of Identification used |  |  |  |  |  |  |                               | If Other, specify |  |        |  |  |        |  |  |
| Identity Number        |  |    |  |                                      |  |  |  |  |  |  |                               | Male              |  | Gender |  |  | Female |  |  |
| Surname                |  |    |  |                                      |  |  |  |  |  |  |                               |                   |  |        |  |  |        |  |  |
| Maiden Surname         |  |    |  |                                      |  |  |  |  |  |  |                               |                   |  |        |  |  |        |  |  |
| Full Names             |  |    |  |                                      |  |  |  |  |  |  |                               |                   |  |        |  |  |        |  |  |
| Client's Contact No.   |  |    |  |                                      |  |  |  |  |  |  | Alt No                        |                   |  |        |  |  |        |  |  |
| Local Office           |  |    |  |                                      |  |  |  |  |  |  | Service point (if applicable) |                   |  |        |  |  |        |  |  |

|                 |   |   |   |   |   |   |   |   |   |   |                                    |  |                |  |        |  |
|-----------------|---|---|---|---|---|---|---|---|---|---|------------------------------------|--|----------------|--|--------|--|
| Assessment Date | D | D | / | M | M | / | C | C | Y | Y | Purpose of Assessment (tick a box) |  |                |  |        |  |
|                 |   |   |   |   |   |   |   |   |   |   | 1st Application                    |  | Re-Application |  | Review |  |

## Part B: Details of SASSA official

|                 |  |                 |  |      |  |
|-----------------|--|-----------------|--|------|--|
| Official's Name |  |                 |  |      |  |
| Signature       |  | Contact No.     |  |      |  |
| District        |  | Assessment Site |  | Town |  |

**Part C: History & Confirmation of Impairment** [Attach relevant report(s) if available]

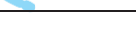
|                                                                   |  |                                                                                     |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
|-------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--------------------------|--------------------------|-----|--------------------------|--------------------------|----------|--------|----------------------------------------------------------|-----|-------------------------------|----|--|
| Has the Health Practitioner confirmed the Identity of the Client? |  |                                                                                     |                          |                          |     |                          |                          |          |        | <input type="checkbox"/> Yes <input type="checkbox"/> No |     | If answer is No, state reason |    |  |
| Presenting complaints                                             |  |  |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
|                                                                   |  |                                                                                     |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
| Is the Client receiving Treatment?                                |  |                                                                                     | <input type="checkbox"/> | Yes                      | No  | Where?                   |                          | Hospital | Clinic | If Other, specify                                        |     |                               |    |  |
| Type of Intervention & Compliance                                 |  | <input type="checkbox"/>                                                            | Yes                      | Medical                  | No  | <input type="checkbox"/> | Yes                      | Surgical | No     | <input type="checkbox"/>                                 | Yes | Rehabilitation                | No |  |
| Elaborate (especially if surgical or rehab):                      |  |                                                                                     |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
|                                                                   |  |                                                                                     |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
|                                                                   |  |                                                                                     |                          |                          |     |                          |                          |          |        |                                                          |     |                               |    |  |
| Relevant Treatment given                                          |  |                                                                                     |                          | Compliance               |     | If No, Elaborate         |                          |          |        |                                                          |     |                               |    |  |
| (a)                                                               |  |                                                                                     |                          | <input type="checkbox"/> | Yes | No                       | <input type="checkbox"/> |          |        |                                                          |     |                               |    |  |
| (b)                                                               |  |                                                                                     |                          | <input type="checkbox"/> | Yes | No                       | <input type="checkbox"/> |          |        |                                                          |     |                               |    |  |
| (c)                                                               |  |                                                                                     |                          | <input type="checkbox"/> | Yes | No                       | <input type="checkbox"/> |          |        |                                                          |     |                               |    |  |
| (d)                                                               |  |                                                                                     |                          | <input type="checkbox"/> | Yes | No                       | <input type="checkbox"/> |          |        |                                                          |     |                               |    |  |

**Part D: Examination / Verification (Assessment of Disability). Attach relevant report(s), if possible**

General Physical Appearance:

Vital Signs if Applicable

|    |  |        |  |        |  |
|----|--|--------|--|--------|--|
| BP |  | Weight |  | Height |  |
|----|--|--------|--|--------|--|

|                  | Functional Curtailment |         |          |        |      | Elaborate                                                                             |
|------------------|------------------------|---------|----------|--------|------|---------------------------------------------------------------------------------------|
|                  | Very Serious           | Serious | Moderate | Slight | None |                                                                                       |
| Cardiovascular   | 1                      | 2       | 3        | 4      | 5    |  |
| Respiratory      | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Neurological     | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| G.I./Metabolic   | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Musculoskeletal  | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Sight            | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Hearing          | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Mental Condition | 1                      | 2       | 3        | 4      | 5    |                                                                                       |
| Other, specify   | 1                      | 2       | 3        | 4      | 5    |                                                                                       |

|                                                                                         |                          |       |          |                          |                                  |                          |  |     |    |                          |
|-----------------------------------------------------------------------------------------|--------------------------|-------|----------|--------------------------|----------------------------------|--------------------------|--|-----|----|--------------------------|
| Results / Reports of Relevant Confirmatory test / Investigations (for scores below 1-3) |                          |       |          |                          |                                  |                          |  |     |    |                          |
| Diagnosis (evidence based) detailing Complications and Prognosis                        |                          |       |          |                          |                                  |                          |  |     |    |                          |
| Is there activity limitation?                                                           | <input type="checkbox"/> | Yes   | No       | <input type="checkbox"/> | If Yes, with assisted device(s)? | <input type="checkbox"/> |  | Yes | No | <input type="checkbox"/> |
| Elaborate [relate to benefits of assistive device(s)]                                   |                          |       |          |                          |                                  |                          |  |     |    |                          |
| Comments on <b>referral</b> form of clinical findings                                   | <input type="checkbox"/> | Agree | Disagree | <input type="checkbox"/> | Elaborate                        |                          |  |     |    |                          |
| Medical Reports / Relevant Confirmatory test(s) provided?                               | <input type="checkbox"/> | Yes   | No       | <input type="checkbox"/> | If Yes, specify                  |                          |  |     |    |                          |

According to Section 30 of Social Assistance Act 13 of 2004, any person is guilty of an offence if he/she intentionally furnishes the Agency with false or misleading information. Section 31 of the same act states that any person convicted of an offence in terms of this act is liable to a fine or imprisonment for a period of not exceeding 15 years.

**I hereby acknowledge that I was assessed by the Health Practitioner**

|                                                                                                                   |                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <br><b>Signature of Client</b> | <b>Thumb Print</b><br><br><b>Thumb print of Client</b> |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|

## Part E: Recommendations

[illegible]

## Clinical Summary

| Diagnosis                                          |                                     |     |    |           |  |
|----------------------------------------------------|-------------------------------------|-----|----|-----------|--|
| Complications                                      | <input checked="" type="checkbox"/> | Yes | No | Elaborate |  |
| Optimal Treatment                                  | <input checked="" type="checkbox"/> | Yes | No | Elaborate |  |
| Refer for further Treatment                        | <input checked="" type="checkbox"/> | Yes | No | Elaborate |  |
| Compliance with Treatment                          | <input type="checkbox"/>            | Yes | No | Elaborate |  |
| Has the Client reached Maximal Medical Improvement | <input type="checkbox"/>            | Yes | No | Elaborate |  |

Severity of Impairment

☐ None ☐ Mild ☐ Moderate ☐ Severe

Does the impairment affect Client's ability to enter open labour market?

☐ Yes ☐ No

## Certification

|                                                                                                                |                          |     |    |                          |              |                          |
|----------------------------------------------------------------------------------------------------------------|--------------------------|-----|----|--------------------------|--------------|--------------------------|
| Having conducted the assessment and considering the findings I certify the applicant to be having a disability | <input type="checkbox"/> | Yes | No | <input type="checkbox"/> | Inconclusive | <input type="checkbox"/> |
|----------------------------------------------------------------------------------------------------------------|--------------------------|-----|----|--------------------------|--------------|--------------------------|

**Social Assistance / Grants Recommended**

|                  |                          |     |    |                          |                           |   |   |   |   |    |    |    |                          |             |    |  |                                 |  |
|------------------|--------------------------|-----|----|--------------------------|---------------------------|---|---|---|---|----|----|----|--------------------------|-------------|----|--|---------------------------------|--|
| Disability Grant | <input type="checkbox"/> | Yes | No | <input type="checkbox"/> | Temporary                 |   |   |   |   |    |    |    | <input type="checkbox"/> | Permanent   |    |  | If with review.<br>Review after |  |
|                  |                          |     |    |                          | Indicate period of months | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Yes                      | With Review | No |  | Years                           |  |

|     |  |  |     |    |  |                                                                               |
|-----|--|--|-----|----|--|-------------------------------------------------------------------------------|
| GIA |  |  | Yes | No |  | If the Client's Disability necessitates regular attendance by another person. |
|-----|--|--|-----|----|--|-------------------------------------------------------------------------------|

|                                                  |  |
|--------------------------------------------------|--|
| Additional Information for subsequent assessment |  |
|                                                  |  |

## Part F: Declaration

The Health Practitioner is also bound by Sections 30 and 31 of Social Assistance Act 13 of 2004 as highlighted above.

I hereby declare that I have examined the identified Client. All particulars furnished by me in this assessment report are true and correct to the best of my knowledge.

Please write legibly and in CAPITAL LETTERS

|                         |      |   |   |   |   |   |   |                |  |  |  |
|-------------------------|------|---|---|---|---|---|---|----------------|--|--|--|
| Practitioner Full Names |      |   |   |   |   |   |   |                |  |  |  |
| Contact Details         | Tel: |   |   |   |   |   |   | Cell:          |  |  |  |
| HPCSA Number            |      |   |   |   |   |   |   |                |  |  |  |
| Practitioner Signature  |      |   |   |   |   |   |   | Official Stamp |  |  |  |
| Date                    | D    | D | / | M | M | / | C |                |  |  |  |

**SASSA reserves the right to conduct quality assurance on all completed Functional or Medical Assessment reports.**

Ref No.:

DG

SASSA Official Stamp