Ref No.: CDG

SASSA Official Stamp

sassa
SOUTH AFRICAN SOCIAL SECURITY AGENCY

FUNCTIONAL/MEDICAL ASSESSMENT
CARE DEPENDENCY GRANT

Instructions on completing 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: Caregiver's Particulars (To be filled by SASSA Official)

Form of identification		ID	Other methods of identification	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)	

Part B: Child's Particulars (To be filled by SASSA Official)

Form of identification		Birth Certificate	Other methods of identification used	If other specify
Identity Number				Male / Gender / Female
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 (thick a box)	1st Application / Re-Application

Is the child attending: Mainstream / Special School / ECD / Daycare / Stimulation
Is the child staying at: Home with parents/guardian / Care Centre

Part C: To be completed by SASSA Official

Official's Name			
Signture		Contact No.	
District		Assessment Site	Town

Part D: To be completed by Health Practitioner

Child referred by: School / Social Worker / Paediatrician / NGO / If other specify

Please note that referral documentation should be attached to this form

Presenting complaint according to caregiver

Presenting complaint according to child (After probing)

When was the health condition of the child diagnosis? Months / Years

Is the client receiving treatment? Yes / No — Where? Hospital / Clinic / If other specify

Type of intervention: Medical / Surgical / Rehabilitation

Elaborate (Especially if surgical or rehab):

How has the child's condition progressed? Improved / Remained the same / Deteriorated

Relevant treatment given		Compliance		Elaborate
1.		YES	NO	
2.		YES	NO	
3.		YES	NO	
4.		YES	NO	
5.		YES	NO	

Part E: Examination/Verification (Activity Limitation Assessment)

General Physical Appearance

Age | 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/Metabolical	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	
Development milestone related to age	1	2	3	4	5	
Other specify	1	2	3	4	5	

Communication (listening, reading and understanding) Age approriateness — Yes / No
Elaborate:

Communication (talking or signing) Age approriateness — Yes / No
Elaborate:

Feeding and mealtime skills, Age approriateness — Yes / No
Elaborate:

Hygiene and grooming skills (Bathing,dressing & toileting) — Yes / No
Elaborate:

Mobility	Age appropriatenes Thick Yes or No		Elaborate
Sitting	Yes	No	
Crawling	Yes	No	
Standing-alone	Yes	No	
Walking-independently	Yes	No	
Running	Yes	No	

The child prefers to play: Alone with toys / With other children / With mother / Only with siblings

Diagnosis (evidence based) detailing complications and prognosis:

Is there any permanent activity limitattion? Yes / No — Is there anticipated benefit from assistive device? Yes / No
Elaborate

Medical Reports/Relevent Confirmatory test(s) provided? Yes / No — If Yes, specify

The child requires permanent care or support services: Yes / No
Comments on referral form of clinical findings: Agree / Disagree — Elaborate

According to Section 30 of Social Assistance Act 13 of 2004 any person guilty of any 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 not exceeding 15 years.

I hereby acknowledge that my child was assessed by the Health Practitioner

Signature of client | Thumb Print L R | Thumb print of client

Part F: Recommendations

Clinical Summary — Identity number

Diagnosis:
Complications:

Is the caregiver ensuring adequte compliance? Yes / No
Has the child reached maximal improvement? Yes / No

Does the child have a permanent disability that warrants permanent care or support services? Yes / No / Inconclusive

YES / CARE DEPENDENCY GRANT RECOMMENDED / NO — YES / REVIEW / NO — IF YES REVIEW AFTER ___ YEARS

Additional Information for subsequet assessment

Part G: Declaration

Practitioner's full names		
Contact details	Tel:	Cell:
HPCSA Number		Official Stamp
Practitioner's Signature		
Date	D D / M M / C C Y Y	

SASSA reserve the right to conduct quality assurance on all completed Medical Assessment reprts.