sassa
SOUTH AFRICAN SOCIAL SECURITY AGENCY

File Coversheet

BRM File Number:
I4052931
CLM Number:
GAU317415506

2022/08/24
Approved - Main
Rejected - Archive
Loose Correspondence
Review

PINKY ELSIE KUNENE	6302090468087
Gauteng	Disability Grant
Transaction Date:	2022/08/16
Date Last Reviewed:	Archive Year: 2022

6302090468087(Id)

GAU317415506

I4052931

General Particulars

- [x] Identity document of Client
- [ ] Identity document Spouse/Partner
- [ ] Death Certificate
- [ ] Decree of Divorce
- [ ] Affidavit - Regulation 11 (1)
- [ ] Marriage Certificate
- [x] Medical Certificate - Disability
- [x] SASSA Affidavit Disability Grant

Particulars of Income

- [x] Income Affidavit
- [ ] Salary or Wage
- [ ] Profits, withdrawals or other Benefits from a Business or Farm(owned)
- [ ] Payments from Trust/Inheritance
- [ ] Payments from Property Rights
- [ ] Pension/Annuity
- [ ] Ex- Gratia Payments Received
- [ ] Maintenance Received
- [ ] Rental Income
- [ ] Profits, Withdrawals or Other Benefits from a Business or Farm(rented)
- [ ] Income from Assets(interest/dividends)
- [ ] Income from RSA/International Org.
- [x] Three (3) Month's Bank Statements or confirmation if new account

Particulars of Assets

- [ ] Immovable Property owned / held under leashold (not occupied)
- [ ] Immovable Property owned / held under leashold (occupied by client/spo
- [ ] Investments, Bonds, Loans, Outstanding debts owed to client and/or spo
- [ ] Shares, Share Capital, Interest in Assets in a Company / Institution
- [ ] Endowed Policies after Maturity or Cash in hand
- [ ] Property Rights
- [ ] Lump sum Invested in order to Procure an Annuity

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FILE COPY

6302090468087

PE KUNENE

281 CORNWELL STR
EXT 7
LANGAVILLE
1550

0 (PAYPOINT)

REGIONAL EXECUTIVE
MANAGER
SASSA
PRIVATE BAG X120
MARSHALLTOWN
2107
Tel : 011 241 8300
Fax : 011 241 8301
2022-08-16

Dear Sir/Madam

APPLICATION FOR A DISABILITY GRANT IN TERMS OF THE SOCIAL ASSISTANCE ACT, 2004 (ACT NO. 13 OF 2004), AS AMENDED

Your application for a disability grant dated 20220816 refers.

After due consideration, we regret to inform you that your application has been unsuccessful, for the following reasons.

In terms of Section 9(2) of the Social Assistance Act, 2004 (Act No. 13 of 2004) read with Regulation 3(2), a person qualifies for a disability grant if the disability is confirmed by an assessment which indicates that the disability is permanent (it will continue for longer than 12 months) or temporary (it will continue for a period between 6 and 12 months). There is little, if any, significant residual impairment affecting your ability to work and you occasional symptoms can be treated and controlled with medication from your treatment centre when necessary. In view of this, you do not qualify for the grant you applied for.

Should you be aggrieved by a decision made with regards to this application, you or a person acting on your behalf, may within 90 days from date of receipt of this letter lodge an appeal in terms of sect ion 14 of the act with the Independent Appeals Tribunal. Your appeal application using the applicable form must set out the reasons why you disagree with the decision of the Agency.

If there is any uncertainty with regard to this notification kindly contact your local SASSA office.

Yours faithfully,

REGIONAL EXECUTIVE MANAGER

SASSA
PRIVATE BAG X1015
2022 -08- 16
GERMISTON 1400
GAUTENG REGION
SERVICE OFFICE 7

This letter will be available in an official language of your choice on request, where applicable.
12 : REFUSAL DISABILITY GRANT , ENGLISH

Y	_	_	24. Three (3) Month's Bank Statements or confirmation if new accoun
N	_	_	25. Immovable Property owned / held under leasehold (not occupied)
N	_	_	26. Immovable Property owned / held under leasehold (occupied by cli
N	_		27. Investments, Bonds, Loans, Outstanding debts owed to client and
N	_	_	28. Shares, Share Capital, Interest in Assets in a Company / Institu
N	_	_	29. Endowed Policies after Maturity or Cash in hand
N	_	_	30. Property Rights
N	_	_	31. Lump sum Investment in order to Procure an Annuity
Y	_	_	34. Medical Certificate - Disability
Y	_	_	38. SASSA Affidavit Disability Grant
N	_	_	44. Salary Slip With Tax Deduction
N	_	_	45. Salary Slip With Pension Fund Contribution
N	_	_	46. Salary Slip With Medical Aid Contribution

** PLEASE NOTE !! **

*** THIS APPLICANT'S DISABILITY GRANT IS REFUSED

N	_	_	50. Annexure C/Consent form

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
Prev. Top Bot. -Pg. +Pg. <Pg. >Pg. Main Prev.

PLEASE ENTER 'Y', 'M' (1990)
DG DOCUMENT CHECKLIST
Client Spouse Dep.Child Y=Received M=Missing N=Not Applicable

y			1. Identity document of Client
	N		2. Identity document Spouse/Partner
N			3. Death Certificate
N			4. Decree of Divorce
N			5. Affidavit - Regulation 11 (1)
N			6. Marriage Certificate
y			12. Income Affidavit
n			13. Salary or Wage
n			14. Profits, Withdrawals or other Benefits from a Business or Par
n			15. Payments from Trust/Inheritance
n			16. Payments from Property Rights
n			17. Pension/Annuity
n			18. Ex- Gratia Payments Received
n			19. Maintenance Received
n			20. Rental Income
n			21. Profits, Withdrawals or Other Benefits from a Business or Par
n			22. Income from Assets(interest/dividends)
n			23. Income from RSA/International Org.

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10--PF11--PF12---
ENTR Pg.- Pg.+ Pg.< Pg.> MAIN PREV

PLEASE ENTER 'Y', 'M' (1990)

y			24. Three (3) Month's Bank Statements or confirmation if new acco
n			25. Immovable Property owned / held under leasehold (not occupied)
n			26. Immovable Property owned / held under leasehold (occupied by c
n			27. Investments, Bonds, Loans, Outstanding debts owed to client s
n			28. Shares, Share Capital, Interest in Assets in a Company / Inst
n			29. Endowed Policies After Maturity or Cash in Hand
n			30. Property Rights
n			31. Lump sum invested in order to Procure an Annuity
y			34. Medical Certificate - Disability
y			38. SASSA Affidavit Disability Grant
n			44. Salary Slip With Tax Deduction
n			45. Salary Slip With Pension Fund Contribution
n			46. Salary Slip With Medical Aid Contribution
n			47. Salary Slip With UIF Contributions
n			48. Letter from Medical Aid
n			49. Letter from Pension Fund/Provident Fund/Insurance Company
n			50. Letter from SARS With Regards To Tax or UIF
N			51. Annexure C/Consent form

Enter-PF1---PF2---PF3---PF4---PF5---PF6 PF7---PF8---PF9---PF10--PF11--PF12---
ENTR Pg.- Pg.+ Pg.< Pg.> MAIN PREV

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Form No :700002779053

GRANT APPLICATION RECEIPT

Social Assistance Act, 2004 (Act Number 13 of 2004)
The below requirements have been discussed with the applicant
who understands the contents thereof.

SECTION A: APPLICANT
Surname .....: KUNENE
Name(s) .....: PINKY ELSIE
Application Date .....: 20220816
Identity Number .....: 6302090468087 Alternative ID Number :
ID Type .....: ID DOCUMENT

SECTION B: PROCURATOR
Surname .....:
Name(s) .....:
ID No. .....: 0
Grant Type .....: DG

If your grant is approved:
- You are required to inform SASSA of any change in your and / or your spouse's / the applicant's circumstances either financial, personal and or your residential or postal address.
Failure to keep SASSA informed of changes may result on you not receiving written communication from SASSA, which may result in you grant being suspended.
- You have chosen one of the two payment methods (either the SASSA/SAPO card or your personal bank account) during the application process - and have been informed that you may change the method of payment at any time by visiting a SASSA office to assist with the change.

P. kunene	220816
Signature: Applicant / Procurator	Date
Left Thumbprint	Right Thumbprint

	22/08/16	Refilwe Mpe
Signature: Designated Officer	Date	Name & Surname

NB: You will be informed three (3) months in advance should you need to review or complete a life certificate.

Helpdesk Enquiry Number: 0800 60 10 11

In accordance with Section 18(1) of the Act, you have the right to request SASSA to reconsider its descision by reporting to the local office nearest to where you stay within 90 days from the date of receipt of this letter.

SOCIAL GRANT FRAUD AND CORRUPTION CALL CENTER NO:
0800 601 011

SASSA Official Stamp

SASSA
PRIVATE BAG X... 13
2022 -08- 16
SPRINGS LOFFICE 05

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Form No (SSD/SCP/GG)

GRANT APPLICATION FORM

Instruct use on completing this Form:
1. This form must be completed in the presence of a SASSA official.
2. Mark with an X in the appropriate box where relevant.
3. Complete in CAPITAL letters and write inside the boxes where applicable.
4. N means No.
5. N means No.

Type of Transaction: New Application ✓ Re-Application
Type of Grant: CG PG CDG FCG
FOR OFFICE USE ONLY

	VERIFICATION	APPLICATION CAPTURE
	Form completed by:	Form Captured by:
Name		
Surname		
User Id		
Signature		
Date	20220316	

Payment Information

Monthly Amount ...: R

Arrear Amount ...: R

Total Payment Qty: R

Month Payable ...

Payment Delivery Method

Collection Point permanently Posted to Applicant ...: Y N

Provide Registered Cell number, if letter not received ...:

Letter sent by:

Date :

SECTION A: PERSONAL DETAILS

Identification Type : ID DOCUMENT Gender : FEMALE
Passport Expiry Date : 0 Temporary SA Expiry Date : 0
Identity Number : 0000000000007 Title : Mrs
Alternative ID Number : 0 Affidavit Attached : Y N

Was an Identity Document available? No Date of Receipt : 0

Surname : KUNENE
First Names ..... John Khoza
Initials .... JK Date of Birth : 1968/02/03
Maiden/Alt Surname : Dlamini
Correspondence Language ... ENGLISH Residential Code: 730800
Application Date : 20220316

Residential Address
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
Postal Code 1150

Postal Address
[illegible]
[illegible]
[illegible]
[illegible]
Postal Code 1510

Is Application lodged by a person on a state institution? Yes No ✓
"Proof of" Parentage to be provided before payment can be effected.
Relationship : MOTHER KINSHIP
Recipient .... Jessie Nonhlanhla
Applicant Relationship Number : 0035877705
No Number of Spouse .....: 0
Spouse Date of Birth .....: /

SECTION B: BANK OF PAYMENT

Method of payment : SASSA/EASY
Details of Bank Account Details
Bank Name : SOUTHERN : SA POSTBANK SOC LTD
Name of Account Holder : MF MSIMANG
Account Type : Savings Cheque Account Number : 0014757705

Form No :7003117778053

SECTION 3. FINANCIAL DETAILS

		: Applicant	Spouse/s	Dependant Child
ASSETS (For grants for Older Persons, War Veterans & Disabled only)				
P (F (Not | ity ried) Occupied	Municipal Value ....>	R 0	R 0	R 0
		Municipal Value .... >	R 0	R 0	R 0
		Outstanding Bond ....>	R 0	R 0	R 0
Cash/Investments		Cash/Investments/Bonds or Loans ....>	R 0	R 0	R 0
		Outstanding debts in favour of applicant/or spouse ....>	R 0	R 0	R 0
		Shares, share capital or interest in assets .....>	R 0	R 0	R 0
		endowment policies after maturity date .....>	R 0	R 0	R 0
		Cash in hand .....>	R 0	R 0	R 0
		Proper y right .....>	R 0	R 0	R 0
		Lump sum invested with aim of providing Annuity ..>	R 0	R 0	R 0
Assets Donated		.....>	R 0	R 0	R 0
Date of donation		D D Y Y M M D D			
INCOME:		(Taken into Account for all Grant Types except Foster Child)			
		Compensation in cash or kind .....>	R 0	R 0	R 0
		Trading, withdrawals or Rent in Your farm or Business .. ..>	R 0	R 0	R 0
		Income from Trust/Inheritance .....>	R 0	R 0	R 0
		Income from property rights .....>	R 0	R 0	R 0
		Pension or Annuity ....>	R 0	R 0	R 0
		Ex-Gratia payments received ....>	R 0	R 0	R 0
		Rental Income ....>	R 0	R 0	R 0
		Maintenance received ....>	R 0	R 0	R 0
		Interest, Dividends ....>	R 0	R 0	R 0
		Other (Specify) ....>	R 0	R 0	R 0
		Income from SP or Informal Self Organisation ....>	R 0	R 0	R 0
Income Donated		....>	R 0	R 0	R 0
Date of donation		C C Y Y M M D D			
PERMISSABLE DEDUCTIONS		Medical Aid ....>	R 0	R 0	R 0
		Pension/ provident fund or retirement annuity contribution .....>	R 0	R 0	R 0
		Tax .....>	R 0	R 0	R 0
		UIF .....>	R 0	R 0	R 0

[illegible]

Section 3: SPORTS ANNUAL REQUIREMENTS
Must attend by an instructor approved by the coach? Y ___ N ___

1. Disability Group
Disability Assessment Facility
Re: Needed by Medical Officer: Y ___ N ___
Re: Home Y ___ N ___
Temporary Y ___ N ___
Temporary Duties to Resume Not Recommended by Medical
To Review Recommended by Medical Officer: Y ___ N ___
Review Period
Disability Assessment Committee

[illegible]

Form SASSA 3000/2022

DECLARATION BY APPLICANT (AFFIDAVIT)
I, the undersigned, hereby apply/ apply on behalf of the Applicant, for the grant as indicated on the applicable form and declare that:

a) all information furnished on this form including financial particulars annexures are - to the best of my knowledge and believe true and correct;

b) I am aware that any false declaration is punishable by law;

c) I undertake to notify SASSA of any change in my circumstances/ circumstances of the Applicant relating to this application;

d) the address provided is valid and complete address to where all official correspondence will be sent;

e) I further take to notify SASSA of any change to my/ the Applicants address

f) I am the Applicant as are mentioned - in this under instruction;

I hereby agree / do not give consent to SASSA to confirm my indicators specified with any financial institution in terms of regulation 30 to the Social Assistance Act, 13 of 2004.

I consent / give / do not give consent under Section 68(5)(b) of the Tax Administration Act, 2011, that the South African Revenue Services (SARS) may disclose information to SASSA to confirm my indicators specified with SASSA.

* Delete one which is not applicable

P. Kunene	2022-08-16
Signature or Thumbprint of Applicant	Date
Left Thumbprint	Right Thumbprint

Remarks	Official Stamp
	SASSA PRIVATE BAG X10 GERMISTON 1400 GAUTENG SOUTH

The above statment was explained to the Applicant/Procurator and he/ she is satisfied with the contents thereof.

The Applicant/Procurator was asked the following questions:

a) Are you conversant with the contents of the above declaration and do you understand it? (Yes) No

b) Do you have any objection to taking the oath/declaration? Yes (No)

c) Do you regard the oath/declaration as binding on your conscience? (Yes) No

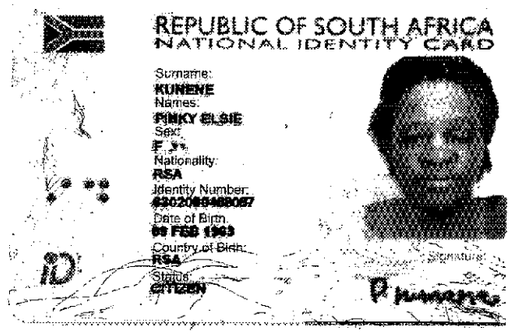
Thus signed and sworn / confirmed to on this 16 day of 08 2022, the deponent having acknowledge that he / she knows and understands the contents of this affidavit, has no objection to taking the oath / affirm the affidavit, having sworn / confirmed that the contents thereof are true and correct and that he / she considers the oath / declaration to be binding on his / her conscience

Signature: Attesting Officer

Name & Surname

Signature: Verifying Officer

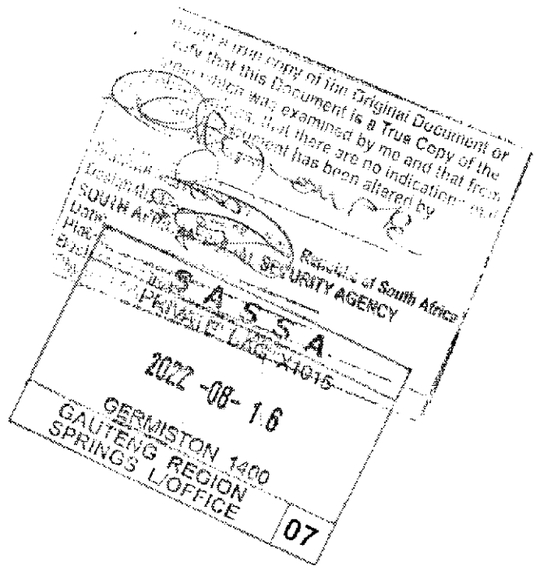
Name & Surname


REPUBLIC OF SOUTH AFRICA
NATIONAL IDENTITY CARD

Surname:
KUNENE
Names:
PINKY ELSIE
Sex:
F
Nationality:
RSA
Identity Number:
6202080488087
Date of Birth:
08 FEB 1962
Country of Birth:
RSA
Status:
CITIZEN

Signature:

ID


I hereby certify that this is a true copy of the Original Document or that this Document is a True Copy of the Document which was examined by me and that from such examination, that there are no indications that the Document has been altered by

Republic of South Africa
SOUTH AFRICAN SOCIAL SECURITY AGENCY
S.A.S.S.A.
PRIVATE BAG X1015
2022 -08- 16
GERMISTON 1400
GAUTENG REGION
SPRINGS LOFFICE
07

ASSESSMENT FORM QUALITY CHECKLIST

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SOUTH AFRICAN SOCIAL SECURITY AGENCY

Assessment Site	Springs	Assessing Doctor	Dr Mashabela
Assessment Date	2022/08/16	Medical Assessment Form number	75320575
SASSA Official on site	Emmanuel khulu		

Name of beneficiary: P.E. Lukhele

ID No. 6 3 0 2 0 9 0 4 4 5 0 8 7

(Please mark with an X where appropriate)

Grant Type		X	**DG**		**CDG**		**GIA**
	New Application	X	**Re-Application**		**Review**		

A. DATA COMPLETENESS (TO BE CONDUCTED AT THE ASSESSMENT SITE BEFORE THE ASSESSOR LEAVES)

Rating Mark with X	**Very Good**	**Good**	**Average**	**Poor**	**Very poor**
General Completeness of the form		X			

	Yes	No
Does client information on referral form correlate with information on assessment form	✓	
Has the consent form been signed by applicant and witnessed	✓	
Full name and ID of the applicant /child indicated on the assessment form	✓	
All fields in Section A of assessment form completed by SASSA official	✓	
Writing legible and readable	✓	
Signatures /thumb prints of client	✓	
Name and contact no. of the medical officer	✓	
Hospital/Official stamp/MPO no.	✓	

Name of Quality Checker:
Print full name and Surname: Emmanuel Khulu

Signature of Quality Checker

REMARKS:

16 Aug 2022
07:30

Medical Assessment Appointment Card

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SOUTH AFRICAN SOCIAL SECURITY AGENCY

ID No of client	630209-0965087				
Name of Client	Pinky Kelsie				
Surname	Konane				
Issuing SASSA Official	Zanele			Date of issue	
Appointment Date				Appointment time	
Assessment Site/Venue					
Type of Grant	DG ✓	CDG	GIA		
	NEW	RE ✓	REV		

Attention: Bring Along the following to the assessment venue

- ID Book/ Affidavit/ Alternative ID
- Spouse's ID Book
- Marriage certificate/ Death Certificate/ divorce Degree
- Child Birth Certificate
- 3 Months bank statement/ Payslip/ proof of private pension
- Medical records including referral form
- Medication
- Any other documentation that can support your application

NB: Should you miss your appointment date, please contact your local SASSA office to rebook.

Tel No.: 011 739 0717/ 16/23/33/02/21/07

Ref No 38A55A

SASSA Official Stamp
2022-07-12
SPRINGS 1560
SPRINGS LOCAL OFFICE

MEDICAL ASSESSMENT: REFERRAL FORM

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SOUTH AFRICAN SOCIAL SECURITY AGENCY

simplicate or ... Please write legibly and in capital letters
This form must not be handed over to Client
Mark with ✓ where applicable

Part A: CLIENT'S PRIMARY INFORMATION (To be filled by SASSA Official)

Identity Number	6302090465057			Male / Female	X female
Form of Identification	ID	Other methods of identification used			
Surname	Kgwete				
Full Names	Pinky	Elsie			
No of applications in last 12 months		Client received TDG in last 12 months		Yes / No	N
Official's Name	[illegible]				
Socpen user ID		Contact no		Town	Springs

Issuing official's signature

Part B: CLIENT'S MEDICAL HISTORY (TO BE COMPLETED BY TREATING CLINICIAN)

(Tick as appropriate) * Regular means clinical care for a period of 6 months or more by an independent clinician, clinic or hospital

I have confirmed the client's name & ID no	✓ Yes / No	
Are you the client's regular* clinician?	✓ Yes / No	
If you answer no above, what supports your completing this form? e.g. obvious impairment	Elaborate:	
Presenting problems/symptoms	[illegible]	
Diagnosis	[illegible]	
Complications, if any		
The client is compliant with treatment	✓ Yes / No	The client abuses substances: Yes / No ✓

How has the medical condition changed over the past 6 months?	Improved	✓ Stabilized	Worsened

Elaborate on progress of condition: [illegible]

Is the health condition preventing the client from being employed?	✓ Yes / No
Elaborate:	

Part C: DECLARATION

All information furnished by me in this referral form is true and correct to the best of my knowledge.

Warning! 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: A person convicted of an offence in terms of this Act is liable to a fine or imprisonment for a period not exceeding 15 years or to both fine and such imprisonment.

Clinician's full names	[illegible]
Clinician's signature	
Date	[illegible]
Tel:	[illegible]
Cell:	

EKURHULENI METROPOLITAN
PUBLIC HEALTH
2022-07-01
SPRINGS CLINIC
HEALTH & SOCIAL DEVELOPMENT
SPRINGS SDC

MP / OTMP / PT / SANC [illegible]

Mark with ✓ the correct box and supply relevant practitioner no.

SASSA will verify the credentials of the referring clinician and reserve the right to conduct quality assurance an all the completed medical referral form.

ANNEXURE I-2

AFFIDAVIT FOR A DISABILITY GRANT

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SOUTH AFRICAN SOCIAL SECURITY AGENCY

I, the undersigned

Surname	Kwapane
Full names	Funky Robie
Identity Number	6302025104 08 5 Age
Residing at (physical address)	25 Corowell Street
	Pet Concordville Postal Code 7532

Do hereby state under oath that I am applying for a Disability Grant. I confirm that I am not residing in an institution funded by the state.

Marital Status (mark appropriate box with X)								
Married					Unmarried			
In community	Out of community	Civil Union	Customary Union	Asiatic Religion	Never Married	Divorced	Widow / Widower	Deserted > 3 months

To be completed if Married / Divorced / Widow(er)

My (ex) spouse / partner's full names & surname	
	ID

If applicant has more than one spouse, indicate details of each spouse on the back of this form.

State reasons if applicant does not have any of the following documents for his/her (ex) spouse or partner.

ID Document	Decree of Divorce	Death Certificate
Reason		

Sources of Income	(mark X in applicable box)			
Type of Income/Profits	Self	Spouse	Dependent Child	N/A
Salary or wage				X
Profits, Withdrawals or other Benefits from a Business / Farm (owned)				X
Payments from a Trust or Inheritance				X
Payment from Property Rights				X
Pension or Annuity				X
Extra ordinary Payments Received ex				X
Rental Income				X
Profits, Withdrawals or other Benefits from a Business / Farm (rented)				X
Income from Assets (interest / dividends)				X
Income from any RSA or International Organisation				X

If the applicant and / or spouse have NO source of income, please indicate below how he / she currently survive

By doing piece jobs when available

Declaration of my / my spouse or partner's Assets (mark appropriate Box/es with X)

Immovable property owned / held under leasehold (not occupied)		Immovable property owned / held under leasehold (occupied)		Investments, bonds, loans, outstanding debts due to you		Shares, share capital, interest in assets in a company / institution		Endowment policies after maturity or cash in hand		Property rights		Lump sum invested in order to procure an annuity		I / we do not own ANY assets	
Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse	Applicant	Spouse
														X	

Declaration

I declare that all information furnished in this affidavit is to the best of my knowledge true and correct. I have no objection to taking the prescribed oath and I consider the prescribed oath to be binding on my conscience.

Deponent's Signature / Thumb Print: P. Funze	I certify that the deponent has acknowledged that he / she knows and understands the contents of this declaration that was sworn to and affirmed before me and that this deponent's signature / thumb print was placed in my presence.	Name of Commissioner:	
Date: 26/5/2022	Place:	Signature, Commissioner of Oath's:	Rank / Force No:

SASSA PRIVATE BAG X10 2022-08-1

Ref No.: A 70320575 **DG**

SASSA Official Stamp

MEDICAL ASSESSMENT: DISABILITY GRANT

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SOUTH AFRICAN SOCIAL SECURITY AGENCY

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: Clients's Particulars (To be filled by SASSA Official)

Form of identification	X ID	Other methods of identification used	If Other specify	
Identity Number			Male / Gender / Female X	
Surname				
Maiden Surname				
Full Names				
Client's Contact No.		Alt no		
Local Office		Service point (if applicable)	Springs	

Assessment date	16 / 08 / 2022	Purpose of Assessment (tick a box)	1st Application / Re-Application / Review
Highest level of education attained	Std 6	Previous Occupation	N/A

Part B: Details of SASSA Official

Official's Name		Socpen user ID			
Signature		Contact no			
District		Assessment Site		Town	Springs

Part C: History & Confirmation of impairment (To be completed by Medical officer) Attach relevent report (s) if available

Has the doctor confirmed the identity of the client?	Yes ✓ / No	If answer is no, state reason	
Presenting complaints	Body pain		
Is the client receiving treatment?	Yes ✓ / No	Where?	Hospital / Clinic / If Other specify
Type of intervention & Compliance	Yes ✓ Medical / No	Yes Surgical / No	Yes Rehabilitation / No
Elaborate (Especially if surgical or rehab):	Dr Mashabela		

Relevant treatment given	Compliance		If no, elaborate
(a) Amlo	Yes	No	
(b) Hydrochlor	Yes	No	
(c) Adco	Yes	No	
(d)	Yes	No	

Part D: Examination/ Verification (Assessment of disability). Attach relevant report (s) & previous assessment form, if applicable

General Physical Appearance: Stable

Vital Signs if Applicable

BP	Weight	Height	RBG

	Functional Curtailment: Very Serious	Serious	Moderate	Slight	None	Elaborate
Cardiovascular	1	2	3	4 ✓	5	HT no complications
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	Controlled HT
Is there activity limitation?	Yes / No ✓ — If yes, with assisted device (s)? Yes / No
Elaborate (relate benefits of assistive device(s))	
Comments on referral form of clinical findings	✓ Agree / Disagree — Elaborate
Medical Reports/ Relevant Confirmatory test (s) provided?	Yes / No ✓ — 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 not exceeding 15 years.

I hereby acknowledge that I was assessed by the medical assessor

P.Kunene

Signature of client | **Thumb print of client** (Thumb Print L R)

Part E: Recommendations

Identity number 6 3 0 2 0 9 0 4 6 8 0 8 7

Clinical Summary

Diagnosis	Controlled HT			
Complications	Yes	No ✓	Elaborate	
Optimal Treatment	Yes ✓	No	Elaborate	
Refer for further treatment	Yes	No	Elaborate	
Compliance with treatment	Yes ✓	No	Elaborate	
Has the client reached Maximal Medical Improvement	Yes ✓	No	Elaborate	
Is the client in a state-funded instution?	Yes	No ✓	If Yes, give name of institution	

The client is expected to be in a state funded institution for a period of: >6/12 / <6/12 / ✓ N/A

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 disabled: Yes / No ✓

Social Assistance/ Grants Recommended

Disability Grant	Yes / No ✓	Temporary — Indicate period in months 6 7 8 9 10 11 12	Permanent — Yes / With Review / No
SRD	Yes / No ✓	If the Disability last for less than six months	
GIA	Yes / No ✓	If the client's disability necessitate regular attendance by another person.	

Part F: Declaration

The assessor 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.

Doctor's full names	DR. PN MASHABELA	
Contact details	TEL NO: 011 056 9058	Cell
MP Number	MP: 0318406	
Doctor's Signature	16 AUG 2022	Dr. Peter Mashabela MBChB (MEDUNSA) PR No 1427172 1979 Tshongweni Section Katlehong Cell 072 378 6226 Email peter.mab @gmail.com
Date	/ /	

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