

2022/05/17



# File Coversheet

BRM File Number:

**I3363645**

CLM Number:

**GAU316325568**

Approved - Main ☐

Rejected - Archive ☒

Loose Correspondence ☐

Review ☐

SIBONGILE W NDABA

Gauteng

Transaction Date:

Date Last Reviewed:

7106070579089

Disability Grant

2022/05/06

Archive Year:

## General Particulars

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Identity document of Client      | <input type="checkbox"/> Identity document Spouse/Partner            |
| <input type="checkbox"/> Death Certificate                           | <input type="checkbox"/> Decree of Divorce                           |
| <input type="checkbox"/> Affidavit - Regulation 11 (1)               | <input type="checkbox"/> Marriage Certificate                        |
| <input checked="" type="checkbox"/> Medical Certificate - Disability | <input checked="" type="checkbox"/> SASSA Affidavit Disability Grant |

## Particulars of Income

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

## Particulars of Assets

- |   |  |
|---|--|
| <input type="checkbox"/> Immovable Property owned / held under leasehold (not occupied)         | <input type="checkbox"/> Immovable Property owned / held under leasehold (occupied by client/spo |
| <input type="checkbox"/> Investments, Bonds, Loans, Outstanding debts owed to client and/or spo | <input type="checkbox"/> Shares, Share Capital, Interest in Assets in a Company / Institution    |
| <input type="checkbox"/> Endowed Policies after Maturity or Cash in hand                        | <input type="checkbox"/> Property Rights   |
| <input type="checkbox"/> Lump sum Invested in order to Procure an Annuity                       |  |

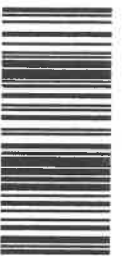
7106070579089(id)



GAU316325568



I3363645



Reprint 2022-05-06

7106070579089

SW NDABA

2972 SIBISI STREET  
DOBSONVILLE  
1863

REGIONAL EXECUTIVE  
MANAGER  
SASSA  
PRIVATE BAG X120  
MARSHALLTOWN  
2107  
Tel : 011 241 8300  
Fax : 011 241 8301  
2022-05-06

0 (PAYPOINT)

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 20220506 refers.

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

In terms of Section 9(b) of the Social Assistance Act, 2004 (Act No. 13 of 2004) read with Regulation 3(c), a person qualifies for a disability grant if he or she is unable to enter the open labour market or to support himself or herself in light of his or her skills and ability to work. There is no objective evidence or supporting documentation of any significant illness or impairment negatively affecting your ability to work and therefore 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 a written application to the Agency, requesting the Agency to reconsider its decision in terms of Section 18(1) of the Act. If you fail to lodge an application within the 90 day time period, your application will not be considered. Your application must set out the reasons why the Agency should amend, vary or set aside its decision.

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

Yours faithfully,



REGIONAL EXECUTIVE MANAGER



S. Molele

STAMP OUT SOCIAL GRANT FRAUD AND CORRUPTION

CALL: 0800 601 011 OR 0800 701 701

This letter will be available in an official language of your choice on request, where applicable.

12 : REFUSAL: DISABILITY GRANT , ENGLISH

Form No : 700002693669

## 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


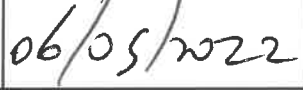




Surname .....: NDABA  
Name(s) .....: SIBONGILE W  
Application Date .....: 20220506  
Identity Number .....: 7106070579089      Alternative ID Number :  
ID Type .....: ID DOCUMENT

### SECTION B: PROCURATOR

Surname .....:  
Name(s) .....:  
ID No. ....: 0  
Grant Type .....:

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 your 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.

			
Signature: Applicant / Procurator		Date	
Left Thumbprint		Right Thumbprint	
			
Signature: Designated Officer		Date	
			
		Name & Surname	
<p><b>NB:</b> You will be informed three (3) months in advance should you need to review or complete a life certificate.</p> <p>Helpdesk Enquiry Number: 0800 60 10 11</p> <p><i>In accordance with Section 18(1) of the Act, you have the right to request SASSA to reconsider its decision by reporting to the local office nearest to where you stay within 90 days from the date of receipt of this letter.</i></p> <p><b>SOCIAL GRANT FRAUD AND CORRUPTION CALL CENTER NO:</b> 0800 601 011</p>		<p>SASSA Official Stamp</p> 	

Form No : 700002693669

## GRANT APPLICATION FORM

### Instructions on completing this form:

1. This form must be completed in the presence of a SASSA official.
2. Mark with and X in the appropriate box where relevant.
3. Complete in CAPITAL letters and write inside the boxes where applicable.
4. Y means Yes.
5. N means No.

Type of Transaction: New Application ☒ Re-Application ☐  
 Type of Grant OA - WV - DG - FCG - CDG - CSG  
 FOR OFFICE USE ONLY

MANUAL COMPLETION		APPLICATION CAPTURE	
Form completed by:		Form completed by:	
Name	SA: SAMSON	Name	SA: SAMSON
Surname	SA: MUREMI	Surname	SA: MUREMI
User ID	SA: P7CE1310	User ID	SA: P7CE1310
Signature	SA: [Signature]	Signature	SA: [Signature]
Date	SA: 06/05/2022	Date	SA: 06/05/2022

### Payment Information

Monthly Amount : R \_\_\_\_\_  
 Arrear Amount : R \_\_\_\_\_  
 First payment of: R \_\_\_\_\_  
 Month Payable : \_\_\_\_\_

### Outcome Delivery Method

Outcome letter personally handed to Applicant ... Y 9 N \_\_\_\_\_  
 Provide Registered post number, if letter not handed over : \_\_\_\_\_  
 Letter sent by: \_\_\_\_\_  
 Date : \_\_\_\_\_

### SECTION A: PERSONAL DETAILS

Identification Type : ID DOCUMENT Gender : FEMALE  
 Refugee Expiry Date : 0 Temporary Id Expiry Date : 0  
 Identity Number : 7106070579089 Title : MISS  
 Alternative ID Number : 0 Affidavit Attached? : Y ☒ N ☐

Receipt from Home Affairs available? No Date on Receipt : 0

Surname : NDABA  
 Full Names : SIBONGILE W  
 Initials : SW Date of Birth : 19710607  
 Applicant Cell Number : 0732763809  
 Correspondence Language : ENGLISH Residence Code: 710400  
 Application Date : 20220506

Residential Address  
 2972 SIBISI STREET

DOBSONVILLE  
 Postal Code 1863

Postal Address  
 2972 SIBISI STREET

DOBSONVILLE  
 Postal Code 1863

Is Application lodged by a person in a state institution? Yes ☐ No ☒  
 Proof of discharge to be provided before payment can be effected.  
 Citizenship : SOUTH AFRICAN  
 Recipient : PERSONAL(SELF)  
 Spousal Relationship Status : NEVER MARRIED  
 ID Number of Spouse : 0  
 Spouse Date of Birth : 0

### SECTION B: METHOD OF PAYMENT

Method of payment : SASSA/SAPO  
 Personal Bank Account Details  
 Bank Name : POSTBANK : SA POSTBANK SOC LTD  
 Name of Account Holder : SW NDABA  
 Account Type : Branch Code : 460005 Account Number : 10010013633

S.w

## SECTION C: FINANCIAL DETAILS

: Applicant Spouse/s Dependant Child

ASSETS (For grants for Older Persons, War  
Veterans & Disabled only)

Property				
(Occupied)	Municipal Value .....	R 0	R 0	R 0
(Not Occupied)	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 afer maturity date .....	R 0	R 0	R 0
	Cash in hand .....	R 0	R 0	R 0
	Property right .....	R 0	R 0	R 0
	Lump sum invested with aim of procuring Annuity ..	R 0	R 0	R 0
Assets Donated	.....	R 0	R 0	R 0
Date of donation	C C 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
	Profits, withdrawals or benetis from 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 SA or International 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	Medical Aid .....	R 0	R 0	R 0
DEDUCTIONS	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

4

S.W

Form No :700002693669

**SECTION D: GRANT SPECIFIC REQUIREMENTS**

Maintained by an Institution subsidized by the State? Y ☐ N ☒

**1. Disability Grant**

Disability Assessment Results:

Recommended by Medical Officer? Y ☐ N ☒

Permanent Y ☐ N ☒

Temporary Y ☐ N ☐

Temporary Period in Months - NOT RECOMMENDED BY MEDICAL OFFICER

Is Review recommended by Medical Officer? Y ☐ N ☐

Review Period

Disability Assessment Remarks:

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G

S:W

**DECLARATION BY APPLICANT (AFFIDAVIT)**

I, the undersigned, hereby apply/ apply on behalf of the Applicant, for the grant as indicated on the application form and declare that:

a) Particulars furnished on this form including financial details/ 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 notification will be sent;




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

f) I am/ the Applicant is not maintained in a state funded institution;

I herby \*give / \*do not give consent to SASSA to confirm my financial standing with any financial institution on terms of regulation 30 to the Social Assistance Act, 13 of 2004.

I further \*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 financial standing with SARS.

\* delete that which is not applicable

	
Signature or Thumbprint of Applicant	Date
Left Thumbprint	Right Thumbprint
Remarks	
<div style="text-align: right;">SASSA Official Stamp</div> 	

The above statement 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 is? ~~Yes~~ **A** No

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

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

Thus signed and sworn / confirmed to on this 06 day of 05 20 22 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

GEREGISTREERDE WOON- EN POSADRES

1. Bewaar die bewys van u GEREGETREERDE WOON- EN POSADRES in hierdie sakke.

2. Indien u van adres verander het, of indien besonderhede van huidige adres, bv. straatnaam en/of -nommer, ens. verander het, moet die vorm KENNISGEWING VAN ADRESVERANDERING, wat in die sakke agter in die identiteitsdokument is, gebruik word om die verandering aan te meld en moet dit ingedien word by of gepos word aan die naaste streek-/distrikkantoor van die DEPARTEMENT VAN BINNELANDSE SAKE.

REGISTERED RESIDENTIAL AND POSTAL ADDRESS

1. Keep the proof of your REGISTERED RESIDENTIAL AND POSTAL ADDRESS in this pocket.

2. If you have changed your address, or, if particulars of your present address, e.g. name of street and/or street number, etc. have been changed, the NOTICE OF CHANGE OF ADDRESS form in the pocket at the back of the identity document must be used to report the change and it must be handed in at or posted to the nearest regional/district office of the DEPARTMENT OF HOME AFFAIRS.

1

I.D.No. 710607 0579 08 9



S.A.BURGER/S.A.CITIZEN

VAN/BURNAME

NDABA

VOORNAME/FORNAME

SIBONGILE WINNIFRED

GESKOORTEDISTRIK OF-LAND/  
DISTRICT OR COUNTRY OF BIRTH

SOUTH AFRICA

GESKOORTEDATUM/  
DATE OF BIRTH

1971-06-07

DATUM UITGEREIK  
DATE ISSUED

1990-09-19

UITGEREIK OP BESAG VAN DIE  
DIREKTEUR-GENERAAL:  
BINNELANDSE SAKE

ISSUED BY AUTHORITY OF THE  
DIRECTOR-GENERAL:  
HOME AFFAIRS



SOUTH AFRICAN POLICE SERVICE  
CLIENT SERVICE CENTRE  
2007-04-29

ERDIE DOKUMENT 'N WARE AFDRUK (AFSKRIF) IS VAN  
'N DOKUMENT WAT AAN MY VIR WAARNEMING VOORGELE  
'N DAT, VOLGENS MY WAARNEMINGS, DAAR NIE 'N  
'N OP DIE OORSPRONKLIKE DOKUMENT AANGE

THIS IS A TRUE REPRODUCTION (COPY) OF THE  
DOCUMENT AS HANDLED TO ME FOR AUTHENTICATION  
BY MY OBSERVATIONS AND I HAVE NOT DETECTED ANY  
DISCREPANCIES WITH THE ORIGINAL DOCUMENT.

SIGNATURE

RANK

RANK

MAGNON  
FORCE N°1  
NAAM IN DRUK  
NAME IN PRINT



## AFFIDAVIT FOR A DISABILITY GRANT



sassa

SOUTH AFRICAN SOCIAL SECURITY AGENCY

I, the undersigned

Surname	N. DABO														
Full names	S. G. A. WENHETLED														
Identity Number	7106070579089														
Age	50														
Residing at (physical address)	2922 SABINE STREET														
Postal Code	1867														

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	Reason	Reason
Reason	Reason	Reason

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

If the applicant and / or spouse have NO source of income, please indicate below how he / she currently survive
By CG. 2 Don't have a bank account

Declaration of my / my spouse or partner's Assets (mark appropriate Boxes 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						

## 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	I certify that the deponent has acknowledged that he / she knows and understand the contents of this declaration that was sworn to and affirmed before me and that the deponent's signature / thumb print was placed in my presence.	Signature: Commissioner of Oaths	Name of Commissioner	Rank / Force No.
			S. G. A.	
Date	20220506	Place	DORBAMUN	

**SASSA**  
PRIVATE BAG X120  
Commissioner /  
06 MAY 2022  
MARSHALLTOWN 2107  
GAUTENG  
REGIONAL OFFICE



# MEDICAL ASSESSMENT FORM QUALITY CHECKLIST

sassa  
SOUTH AFRICAN SOCIAL SECURITY AGENCY

Assessment Site	DOBSONVILLE
Assessment Date	06/05/2022
SASSA Official on site	SAMPSON

Assessing Doctor	D Mosthege
Medical Assessment Form number	A 70386239

Name of beneficiary: SEBONGELE WENZIMHLO

ID No. 7106070579089

(Please mark with an X where appropriate)

Grant Type	<input checked="" type="checkbox"/> DG	<input type="checkbox"/> CDG	<input type="checkbox"/> GIA
<input checked="" type="checkbox"/> New Application	<input type="checkbox"/> Re-Application	<input type="checkbox"/> 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				
Does client information on referral form correlate with information on assessment form					Yes No
Has the consent form been signed by applicant and witnessed					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Full name and ID of the applicant /child indicated on the assessment form					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
All fields in Section A, B and C of assessment form completed by SASSA official					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Writing legible and readable					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Signatures /thumb prints of client					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Name and contact no. of the medical officer					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Official stamp - Hospital/ /MPO no.					<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
Name of Quality Checker	SAMPSON MURRAY				
Print full name and Surname:	SAMPSON MURRAY				
Signature of Quality Checker					

REMARKS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ref No: **SASSA 239 DG**  
PRIVATE BAG X32

**SASSA Official Stamp**  
**2022-05-08**  
**RANDFONTEIN 1760**  
**GAUTENG REGION**  
**DOBSONVILLE OFFICE 06**

## MEDICAL ASSESSMENT: DISABILITY GRANT



**sassa**  
SOUTH AFRICAN SOCIAL SECURITY AGENCY

*Instructions: 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	<input checked="" type="checkbox"/>	ID	Other methods of identification used	If Other specify		
Identity Number	7106070579089			Male	Gender	Female
Surname	MABASA					
Maiden Surname						
Full Names	SIBONGILE W					
Client's Contact No.	0732763809			Alt no		
Local Office	DOBSONVILLE			Service point (if applicable)		

Assessment date	06/05/2022	Purpose of Assessment (tick a box)	
		1st Application	<input checked="" type="checkbox"/> Re-Application
			Review
Highest level of education attained	GRADE 11	Previous Occupation	never worked

### Part B: Details of SASSA Official

Official's Name	S. MABASA	Socpen user ID	276034
Signature	[Signature]	Contact no	0732763812
District	WEST RAND	Assessment Site	DOBSONVILLE

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

Has the doctor confirmed the Identity of the client?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If answer is no, state reason
Presenting complaints	Pain in back, knee, 17/05/2022		
Is the client receiving treatment?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Where? Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> If Other specify
Type of intervention & Compliance	Yes <input checked="" type="checkbox"/> Medical	No <input type="checkbox"/> Surgical	Yes <input type="checkbox"/> Rehabilitation
Elaborate (Especially if surgical or rehab):	JMF		

Relevant treatment given	Compliance		If no, elaborate
(a) Insulin	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
(b) etc	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
(c)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
(d)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	

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

General Physical Appearance:  
Vital Signs if Applicable

BP	Weight	Height	RBG			
	Functional Curtailment					Elaborate
	Very Serious	Serious	Moderate	Slight	None	
Cardiovascular	1	2	3	4	5	<p>DD WEE</p> <p>workshop by 1 (modest)</p>
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)	Xys		JMF @ KNE		
Diagnosis (evidence based) detailing Complications and prognosis	(12) KNE ANTI-MALARIA				
Is there activity limitation?	Yes	No	If yes, with assisted device (s)?	Yes	No
Elaborate on plate to 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

Signature of client: S. Ndase  
Thumb print of client: L R

#### Part E: Recommendations

Identity number: 71 06 07 0579 089

#### Clinical Summary

Diagnosis	(12) KNE ANTI-MALARIA			
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	Fully Recovered
Is the client in a state-funded institution?	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
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

#### 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	Moshug	
Contact details	Tel: 038303	Cell: DR* D* MOSHUG 1
MP Number	TEL: 011 410-6307	
Doctor's Signature	MP 338303	
Date	08/1/2022	

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



12 APRIL

Ref No: 301274957



**sassa**  
SOUTH AFRICAN SOCIAL SECURITY AGENCY

SASSA Official Stamp  
PRIVATE BAG X32

2022-02-01

## MEDICAL ASSESSMENT: REFERRAL FORM

Instructions on filling in the form: Please write legibly and in capital letters

This form must not be handed over to Client

Mark with X where appropriate

GAUTENG REGION  
DOBSONVILLE L/OFFICE

01

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

Identity Number	7 1 0 6 0 7 0 5 7 9 0 8 9	Male	Gender	Female <input checked="" type="checkbox"/>
Form of Identification	<input checked="" type="checkbox"/> ID	Other methods of identification used		
Surname	N D A B A			
Full Names	S I B O N G I L E W.			
No of applications in last 12 months	0	Client received TDG in last 12 months	Yes	No <input checked="" type="checkbox"/>
Official's Name	Gavin			
Socpen user ID	976E014	Contact no	0119896813	Town

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	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Are you the client's regular* clinician?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If you answer no above, what supports your completing this form? e.g. obvious impairment	Elaborate:	
Obvious scar on (R) knee.		
Presenting problems/symptoms	Hx of knee operation @ LRT 2012.	
Diagnosis	(R) Knee Operation - Chronic Pain	
Complications, if any	NAD.	
The client is compliant with treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The client abuses substances	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

How has the medical condition changed over the past 6 months?

☐ Improved

☒ Stabilized

☐ Worsened

Elaborate on progress of condition:

Is the health condition preventing the client from being employed?

☐ Yes

☒ No

Elaborate:

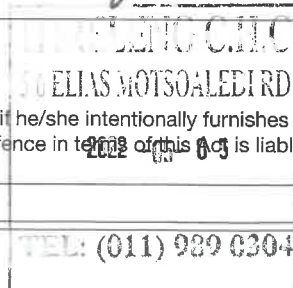
patient clinically stable. Good range of motion of (R) knee + pain will be relieved with pain medication.

### 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	DR. CHARNE ROY.
Clinician's signature	
Date	23 02 - 2022
Tel:	076 75 53437
Cell:	



Treating facility or clinician's official stamp				
<input checked="" type="checkbox"/> MF	<input type="checkbox"/> OTMP	<input type="checkbox"/> PT	<input type="checkbox"/> SANC	092 2 587

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 on all the completed medical referral form.

## CONSENT TO OBTAIN MEDICAL INFORMATION

I, the undersigned

Ndaba Sibongile Winnifred

(Insert full names of applicant)

710607 0579 089

(Insert Identity number)

hereby give permission to any treating clinician/healthcare facility in possession of my medical information to make such information available to SASSA for the purpose of disability related grants application.

Signed at

Durban

(Insert the place)

on

01 / 02

(Insert the date)

2020

[Signature]

SIGNATURE/THUMBPRINT OF APPLICANT / BENEFICIARY

### AS WITNESSES:

1.

Carri Barker

Full names

[Signature]

signature

2.

Gordian Muthana

Full names

[Signature]

signature