ADVANCED ILLNESS / PALLIATIVE CARE APPLICATION FORM

The Advanced Illness Benefit (AIB) is available on all Bestmed options. The AIB gives Bestmed members who have an advanced-stage illness access to a full palliative care programme and is available for "end-of-life" home-based care and "in lieu of hospitalisation" home-based care subject to Bestmed Scheme Rules.

The AIB is funded at 100% Scheme tariff, with an annual benefit limit depending on your option. Pre-authorisation is required. Please send information and documents to **adv.illness@bestmed.co.za**

The AIB includes the following disciplines: palliative doctor/nursing agency/hospice home base visits, and social worker(if needed). This benefit excludes any medicine. feeding supplements, and equipment. All providers that will form part of the Palliative care team, practice numbers. tariff codes and quantity is needed.

This gives you Scheme-approved care in the comfort of your home. The AIB is our *Personally Yours* promise to be by your side, no matter where the journey leads.

1. MAIN MEMBER DETAILS

Title | Membership number

Surname

Full names

ID number

Physical address

Code

Email address

Telephone number | Cell phone number

2. PATIENT DETAILS

Title | ID number

Surname

Full names

Membership number | Dependant code

Physical address

Code

Email address

Telephone number | Cell phone number

Current residential location:

Own home with spouse		Residing with children	
Own home with carer		Retirement village	
Own home living alone			

Membership number | Doctor's practice number

3. ADVANCED CARE PLANNING

Does the patient have an Advanced Care Plan and/or Living Will? Yes | No

If "Yes" please supply the nominated third party's details or the proxy's details:

Title | ID number

Surname

Full names

Relationship

Email address

Telephone number | Cell phone number

By signing consent, I give my permission for the identified next-of-kin to be contacted in order for us to assist with the patient's healthcare needs. I understand that as the patient's condition changes, other care treatment plans may be introduced and I give permission for other multidisciplinary healthcare providers to be contacted.

Member / patient / third party / proxy's signature on behalf of the patient

Date D D M M Y Y Y Y

4. ABOUT THE TREATING DOCTOR/S

1. Treating Doctor Practice number

Surname

Name

Speciality

Email address

Telephone | Cell phone number

Physical address

Code

2. Treating Doctor Practice number

Surname

Name

Speciality

Email address

Telephone | Cell phone number

Physical address

Code

Membership number | Doctor's practice number

5. CLINICAL SUMMARY FOR PATIENTS WITH ADVANCED DISEASE

Date of assessment | D | D | M | M | Y | Y | Y | Y |

Date of disease diagnosis | D | D | M | M | Y | Y | Y | Y |

Have you and your patient discussed why you are applying for this benefit at this stage | Yes | No |

ICD-10 code _____

Number of admissions in the past 6 months. ☐

Treatment intent Palliative ☐ Curative ☐ End-of-life ☐

Is disease directed treatment ongoing? | Yes | No |

If "Yes" provide the type of treatment.

		Treatment date from	Treatment date to
	Radiotherapy		
	Chemotherapy		

6. TO BE COMPLETED BY TREATING DOCTOR

Select the applicable

ECOG Performance status		✓
0	Fully active, able to carry on all pre-disease performance without restriction.	
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.	
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.	
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.	
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.	
5	Dead	
Karnofsky Performance status		✓
100	Normal, no complaints, no evidence of disease.	
90	Able to carry on normal activity, minor signs or symptoms of disease.	
80	Normal activity with effort, some signs or symptoms of disease.	
70	Cares for self but unable to carry on normal activity or to do active work.	
60	Requires occasional assistance, but is able to care for most of his personal needs.	
50	Requires considerable assistance and frequent medical care.	
40	Disabled; requires special care and assistance.	
30	Severely disabled; hospital admission is indicated although death not imminent.	
20	Very ill; hospitalisation necessary and active supportive treatment necessary.	
10	Moribund	
0	Dead	

Lansky Scale (Recipient age ≥ 1 year and < 16 years		✓
Able to carry on normal activity, no special care is needed		
100	Fully active.	
90	Minor restrictions in physically strenuous play.	
80	Restricted in strenuous play, tires more easily, otherwise active.	
Mild to moderate restriction		
70	Both greater restrictions of, and less time spent in active play.	
60	Ambulatory up to 505 of time, limited active play.	
50	Considerable assistance required for any active play, fully able to engage in quiet play.	
Moderate to severe restrictions		
40	Able to initiate quiet activities.	
30	Needs considerable assistance for quiet activity.	
20	Limited to very passive activity initiated by others (e.g. TV).	
10	Completely disabled, not even passive play.	

Membership number | | | | | | | | | | |

Doctor's practice number | | | | | | | | | | |

7. PALLIATIVE CARE PLAN

Medicine

NOTE: Medicine is not part of AIB. Please send you prescription to **medicine@bestmed.co.za**

Item	Dose	Frequency	Duration	Repeat

Other supportive treatment

Social worker		Please sepcify	
Counselling		Please sepcify	
Home nursing (excl. frail care)		Please sepcify	
Oxygen		Please sepcify	
Hospice		Please sepcify	
Referral to palliative care doctor		Please sepcify	

Other:

Additional notes:

Doctor's signature

Date D D M M Y Y Y Y

Membership number

Doctor's practice number

8. CONSENT PROVISIONS BY APPLICANT

1. I hereby expressly make the following acknowledgements in respect of Bestmed's processing of my Personal Information and/or Special Personal Information and/or that of my dependants/child(ren)/spouse(s) ("collectively referred to as "Personal Information"), as defined in terms of the Protection of Personal Information Act, 4 of 2013 (POPIA):
   - 1.1 That I have read and understood the provisions of Bestmed's Data Protection and Privacy Policy, thereby fully appreciating the manner in which Bestmed may process my Personal Information and for which purpose(s) Bestmed may process such Personal Information.
   - 1.2 That through submitting this application, I may be providing Bestmed with the Personal Information of my spouse(s), children and/or other dependant third parties.
   - 1.3 That by engaging with Bestmed through any physical and/or electronic means, Bestmed will in effect be processing the Personal Information provided by me from time to time.
   - 1.4 That Bestmed may from time to time, depending on the circumstances, collect my Personal Information from another source other than myself.
   - 1.5 That I fully appreciate that Bestmed places a high premium on my privacy and/or that of my dependants, spouse(s) and/or children.
   - 1.6 That I have read and understood the undertakings made by Bestmed in its Data Protection and Privacy Policy to the effect that it will ensure that any and all of my Personal Information and/or that of my dependants/child(ren)/spouse(s) shall be processed with a reasonable standard of care as may be expected from Bestmed.
   - 1.7 That I fully appreciate that Bestmed will only process my Personal Information and/or that of my dependants/child(ren)/spouse(s) in a manner consistent with the provisions of its Data Protection and Privacy Policy, as well as for the purpose(s) set forth therein.
   - 1.8 That, in accordance with the provisions of Section 18 of POPIA, I have been provided with adequate notification of the processing of my Personal Information by Bestmed, the scope and purpose(s) for such processing, as well as my rights to object to such processing should I elect to do so.
   - 1.9 That I acknowledge that the processing of my Personal Information is a mandatory requirement for the existence of a valid medical aid.

2. In light of the above acknowledgements, and in accordance with the requirements set forth in Section 11 of POPIA, I hereby provide my specific and informed consent to Bestmed for the processing of my Personal Information and/or that of my dependants/child(ren)/spouse(s), for any purpose(s) legitimately connected or related to my application for membership, which purpose(s) may include, but not be limited to the following:
   - 2.1 To provide or manage any information, products and/or services requested by me pursuant to my application for membership.
   - 2.2 To establish my needs, requirements and preferences in relation to the products and/or services provided by the Bestmed.
   - 2.3 To facilitate the delivery of products and/or services to me as a member of Bestmed.
   - 2.4 To administer my claims and premiums.
   - 2.5 To activate my medical aid and/or prescribed benefits.
   - 2.6 To allocate a unique identifier to me for the purpose of securely storing, retaining, and recalling my Personal Information from time to time, including after my membership is terminated.
   - 2.7 For general administration purposes pertaining to my membership.
   - 2.8 For legal and/or contractual purposes and to enable Bestmed to comply with its contractual obligations towards me.
   - 2.9 To transact with suppliers and business partners, including healthcare service providers, managed facilities, network hospitals, pharmacies and relevant regulatory authorities to facilitate the delivery of products and/or services to me.
   - 2.10 To provide me with health and wellness information throughout the subsistence of my membership.
   - 2.11 To transact with third parties and transfer my Personal Information to such third parties for the purpose of enabling Bestmed to fulfil its contractual obligations towards me.
   - 2.12 To analyse my Personal Information collected for research and statistical purposes.
   - 2.13 To transfer my Personal Information across the borders of South Africa to other jurisdictions should it be required in the legitimate pursuit of Bestmed's business requirements.
   - 2.14 To carry out analysis and profiling of my membership profile.

3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

   Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No

Signature of applicant

Date | D | D | M | M | Y | Y | Y | Y |

Membership number | | | | | | | | | | |

Doctor's practice number | | | | | | | | | | |