APPLICATION FORM

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

COMPLETED APPLICATIONS TOGETHER WITH SUPPORTING DOCUMENTS MUST BE SUBMITTED TO THE RELEVANT DISTRICT OFFICE AND BE ADDRESSED AS FOLLOWS:

THE DISTRICT DIRECTOR:

DISTRICT: _____

DEPARTMENT OF HEALTH – KWAZULU-NATAL

Application is hereby made for funding to subsidize the extension of health services provided by the KZN Department of Health, details of which are supplied below:

1. Details of the applicant

1.1 Name of the institution / organization: _____

1.2 Institution's representative (name & position): _____

1.3 Contact details

Tel: _____

Cell: _____

Fax: _____

E-mail: _____

Other: _____

1.4 Physical address: Postal address:

_____ _____

_____ _____

_____ _____

_____ _____

1.5 Banking details

Account holder: _____

Bank name: _____

Type of account: _____

Account number: _____

Branch code: _____

2. Name and Identity number of Board members / Trustees

Name & surname: Identity number:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. District in which the institution / organization is situated (mark with an X)

uGu	☐	Ethekwini	☐
uMgungundlovu	☐	Ilembe	☐
uMzinyathi	☐		
Amajuba	☐		

4. Categorization and workload of the institution / organization

4.1 Category of the non-profit organization (mark with an X)

Voluntary association	☐
Section 21 company	☐
Trust	☐
Other (specify _____)	

4.2 NPO registration number: _____

4.3 Detailed breakdown of the type of services / the package of service provided

_____

_____

_____

_____

_____

_____

5. The extent of the present demand for the services provided

_____
_____
_____
_____
_____
_____

6. Reasons why this application should succeed (motivation)

_____
_____
_____
_____
_____
_____

7. What are other funding options if this application is not successful

_____
_____
_____
_____
_____

8. Financial status of the institution / organization

8.1 What is the financial status of the institution / organization

Excellent	Good	Fair	Poor	Distressed
☐	☐	☐	☐	☐

Explain: _____
_____
_____

8.2 Are there any debts, claims or other financial commitments that may impact negatively on the institution / organization as a going concern

Yes	No
☐	☐

Details: _____

_____

_____

8.3 What is the exact amount requested for each year over a contracted period

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6

8.4 What is the institution / organization's other source/s of funding and/or any other forms of material support

_____

_____

_____

9. Supporting documents

9.1 Breakdown of the institution / organization's staff complement in line with the guide in Annexure I

Provided	Y ☐	N ☐

9.2 3-year business plan in line with the guideline in Annexure II

Provided	Y ☐	N ☐

9.3 Map of the catchment area indicating other health establishments within the catchment

Provided	Y ☐	N ☐

9.4 Resolutions authorizing a person to sign on behalf of the institution / organization

Provided	Y ☐	N ☐

9.5 Other information / supporting documents provided

	Y	N
NPO registration		
Licence		
Audited financial statement		
Tax certificate		
Annual report		
Other (specify _____)		
(specify _____)		
(specify _____)		

I hereby confirm and certify that all the information, particulars and accompanying documents in this application are true and correct.

Name & surname: _____ Signature: _____

Position: _____ Date: _____