

(3) In the case of a non South African citizen, the leave of absence must be confirmed with the Department of Home Affairs.

CHAPTER XVI
PERSON WHO IS NOT CITIZEN OR PERMANENT RESIDENT OF REPUBLIC OF
SOUTH AFRICA
[Section 49(6)]

Condition for administration or admission of person who is not South African
Citizen or permanent resident to treatment centre

76.(1) Any person who is not a citizen or permanent resident of the Republic of South Africa as contemplated in section 49(6) of the Act may be admitted to a treatment centre for treatment, rehabilitation or skills development on condition that such a person-

(a) is in possession of any form of identification legally recognised in the Republic of South Africa which must associate the person with the country the person claims to originate from; and

(b) in the case of a public treatment centre, resides within the area the treatment centre serves of which some proof in the form of a utility bill or any other relevant document shall be produced upon admission;

(2) In a situation where the form of identification referred to in sub-regulation (1)(a) is not available, the service user applying for admission into a treatment centre must obtain an affidavit from the Department of Home Affairs.

(3) The affidavit referred to in sub-regulation (2) must be signed by the Commissioner of Oaths from the Department of Home Affairs and the Minister of Home Affairs must confirm in the said affidavit that-

(a) the person applying to be admitted in the treatment centre is a citizen of the country the service user claims to originate from;

(b) is legally residing in the Republic of South Africa;

(c) is in need of treatment for substance abuse;

(d) the admission fees and any other fees, where applicable, shall be payable by the service user.

CHAPTER XVII
CONDITIONS FOR SERVICE USER TO HAVE ACCESS TO MANAGEMENT AND
MANAGEMENT TO HAVE ACCESS TO SERVICE USER
[Section 50]

Conditions for access to management structure by service user

77.(1) Any service user may have access to management structure of a treatment centre on condition that the purpose for access relates to-

- (a) personal health records;
- (b) a treatment plan;
- (c) registering a complaint; and
- (d) a general request.

(2) Access contemplated in sub-regulation (1) may be initiated by-

- (a) the service user;

(b) a house committee representative;

(c) a member of the family; or

any person the service user may so choose to communicate the service user's need for access to the management.

Conditions for access to service user by management structure

78. The management structure of a treatment centre may have access to the service user on condition that the purpose for access relates to-

(a) communicating changes regarding policies and rules in the treatment centre;

(b) changes in treatment plan;

(c) changes relating to personnel involved in service users' treatment;

(d) getting personal information related to treatment;

(e) getting information related to personal health; and

(f) Any other matter related to the proper administration of a treatment centre.

CHAPTER XVIII
MAINTENANCE OF DISCIPLINE IN TREATMENT CENTRE, HALFWAY HOUSE,
OUT-PATIENT SERVICES AND COMMUNITY-BASED SERVICES
[Section 51(5)]

Composition of appeal committee

79. The appeal committee, which the Minister must establish as contemplated in section 51(4) of the Act, must comprise of-

- (a) two representatives of the community the treatment centre, halfway house, out-patient centre or community-based centre serves;
- (b) regional manager of the Provincial office;
- (c) one ordinary staff member of the institution concerned who was not involved in the decision against which the appeal is directed; and
- (d) a social worker.

Duties of appeal committee

80.(1) The appeal committee must-

- (a) receive and scrutinise appeals relating to discipline from appellants;
- (b) investigate the appeals referred to in sub-regulation (1)(a) and decide on the action to be taken;
- (c) advise the appellant of the appellant's rights during the appeal process including the right to be represented by a family member or service user or any other person during the hearing and the right to call witnesses where necessary;
- (d) set a date for the hearing of an appeal and communicate that to the appellant and all the relevant people; and
- (e) make a decision on the appeal brought before it and communicate its decision to the appellant in the language the appellant clearly understands.

- (2) The appeal committee may after hearing the appeal-
- (a) confirm the corrective measure against which the appeal is made;
 - (b) set aside the corrective measure;
 - (c) substitute the original decision,

appealed against with the one which in opinion of the appeal committee is more suitable than the one originally decided upon.

(3) The appeal committee must direct the relevant treatment centre, halfway house, community-based centre or out-patient centre to execute the decision of the appeal committee.

(4) The decision of the appeal committee must be in writing and a copy thereof must be furnished to the-

- (a) appellant;
- (b) treatment centre or halfway house or community-based centre or out-patient centre that took the decision to discipline the service user; and
- (c) Department.

CHAPTER XIX
METHOD OF DEALING WITH ABSCONDER FROM TREATMENT CENTRE
[Section 52(6)]

Period for bringing apprehended involuntary service user before magistrate

81. An involuntary service user who has been apprehended after absconding from a treatment centre must be brought before a magistrate within 48 hours of apprehension or as soon as is reasonably and practically possible thereafter.

CHAPTER XX
GENERAL PROVISIONS
[Section 65(3)(b)]

Offenses and penalties

82.(1) Contravention of any of the rules of a treatment centre constitutes an offense and in the case of children the offense is punishable in the following manner:

- (a) First time offense shall carry a penalty of forfeiture of playtime time for a period of a week.
- (b) Second time offense shall carry a penalty of forfeiture of the playtime time for a period of two weeks.
- (c) Third time offense and subsequent times shall carry a penalty of forfeiture of the playtime time for a period of a month.

(2) In the case of adults, the offense is punishable in the following manner:

(a) First time offense shall carry a penalty of 30 minutes of labour in the treatment centre and forfeiture of playtime for a period of a week.

(b) Second time offense shall carry a penalty of 1 hour of labour for 2 days in the treatment centre and forfeiture of playtime for two weeks.

(c) Third time offense and subsequent times shall carry a penalty of 1 hour of labour for a period of two days and forfeiture of playtime for a period of a month.

(3) If a service user breaches more than one rule, the penalty may be doubled.

Short Title and commencement

83. These Regulations are called the Regulations for Treatment of and Prevention for Substance Abuse Act, 2008 and shall come into force by Notice in the *Gazette*.

ANNEXURE**SUMMARY OF FORMS**

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FORM 1**APPLICATION FOR REGISTRATION OF COMMUNITY-BASED SERVICES****PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008 (ACT
NO 70 OF 2008)****(For an applicant that is an organization)**

_____ (full name of organization) herein
represented by _____ (full names and identity number),

in his or her capacity as _____ duly
authorized in terms of resolution no _____ dated _____ (attach a certified
copy of the resolution)

OR**(For an applicant that is an individual)**

_____ (full names and identity number of
individual applicant),

apply for registration of the services listed in section B hereof.

Section A: Basic details of the Service Provider (Organization or individual)

1. Name of Organization/ Individual
2. Registration number (if applicable) Non Profit Organizations number (if any):
 - 2.1 Company or trust registration number (if any):
 - 2.2 Any other registration details (specify):

- a. Has your registration ever been suspended or cancelled:

☐ YES/NO

If yes, please provide details:

3. Address details

3.1 Physical and postal address of Administration Office:

3.2 Physical addresses and telephone numbers of service locations (identify facility)

((I))

 postal code

(ii) _____
_____ postal code _____

(iii) _____
_____ postal code _____

(iv) _____
_____ postal code _____

(If there are more service locations please attach a list)

4. Financial details

4.1 Do you have a bank account?

YES/NO

If yes, provide following details

(i) Bank:

Account name:

Type Account:

Account no:

Branch Code:

4.2 Do you have an auditor?**YES/NO**

If yes, provide details

(i) Name:

(ii) Address :

(iii) Telephone
number:

4.3 Audited Financial Statements

Please attach a copy of your Audited Financial Statements for the past six months.

If you do not have Audited Financial Statements please give the reasons therefore and attach financial reports.

5. Governance Details**5.1 Constitution:** Please attach a certified copy.**5.2 Details of Governing Body:**

Please attach a list of members of your organization with names and identity numbers.

Please disclose and provide details of family interests or relationships pertaining to the organisation and staff:

5.3 Do you hold General Members Meetings

YES/NO

If yes, attach a copy of the minutes of the last meeting

6. Beneficiaries

How many persons benefit from the services provided?

Declaration

I declare that the above information is true and correct. I understand that any misrepresentation or omission of pertinent information may be considered as sufficient grounds for withdrawal of registration.

Signature	Place	Date
-----------	-------	------

Full Name:

Capacity:

Copy of ID to be attached

Section B: Community-based services

1. Name of applicant (as in section A)

(i) Organisation or Company:

(ii) Individual :

2. Description of Community -based care and support services

When was the services first established : (date)

What services are rendered (please tick) (Attach copy of your services plan

☐ Awareness raising

☐ Substance abuse educational programmes

- ☐ Transport
- ☐ Life skills programme
- ☐ Early Intervention
- ☐ Referrals
- ☐ Treatment
- ☐ Aftercare + re-integration
- ☐ Family support services
- ☐ Marriage enrichment services
- ☐ Statutory services
- ☐ Recreation
- ☐ Income Generation
- ☐ Socialisation
- ☐ Culture and Spiritual
- ☐ Home visits
- ☐ Advice
- ☐ Group Support
- ☐ Education and Training
- ☐ Counselling (social work)
- ☐ Temporary accommodation
- ☐ Other, Please specify

On how many days or hours per week do you operate? Tick

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Does the service operate over weekends and public holidays?

3. Beneficiaries

Please give a breakdown of persons who benefit from the services on a weekly basis

(i) Total Number of persons:

(ii) Prevention/early intervention/treatment/aftercare + reintegration

4. Funding of the Services

Do you receive a grant/ subsidy from the Department of Social Development

YES / NO

If yes, what amount do you receive on a monthly basis:

R _____

Do you receive a grant from the local authority

YES / NO

If yes, what amount do you receive per month or per annum:

R _____

Have you applied for funding from the Department of Social Development which was turned down?

YES/NO

If yes give details:

Do beneficiaries pay for the services

YES / NO

If yes what do beneficiaries pay for the services per month/per day/per hour R

_____ per individual?

If no, please give your reasons:

5. Human Resources

Do you have paid staff members

YES / NO

Do you have volunteers?

If so, how many?

Do you pay transport costs of volunteers?

If yes, give breakdown of employed staff and volunteers:

POSITION	NO	TASKS

CONTINUES ON PAGE 162—PART 2

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If you do not use paid staff members, how do you render the services?

(a) Volunteers

YES/NO

(b) Partnership workers, provided by other organizations

YES/NO

How many volunteers on a monthly basis render services _____ and the estimated total hours of volunteer work _____?

6. Service Locations

Provide a list of places and areas where services are rendered.

AREA	PLACE
(i)	
(ii)	
(iii)	
(iv)	
(v)	

If you render services at more locations please attach a list.

Provide sketch plans of the above facilities

Facilities in service delivery (please tick):

- ☐ Hall
- ☐ Offices
- ☐ Kitchen
- ☐ Store Room
- ☐ Dining Room
- ☐ Clinic
- ☐ Library

☐ Bathrooms/showers

☐ Toilets

☐ Wash basins

☐ Other (specify)

If you do not have the above facilities at your disposal, how do you render the services?

Give details:

Basic amenities and equipment to render services

Please tick below:

☐ Kettle or urns

☐ Stove

☐ Fire

☐ Fridge

☐ Water supply

☐ Power supply

☐ Catering utensils

☐ Plates, cups etc

☐ Tables and chairs

- ☐ Recreation equipment
- ☐ Primary Health Care equipment
- ☐ Assistive devices (wheel chairs, tripods, commodes, walking sticks)
- ☐ Other, provide list:

Please attach a list of the equipment used in the facility

7. Business Plan

Do you render your services according to a business plan?

YES/NO

If yes, please attach your business plan to section B

If no, please indicate the reasons below:

- ☐ A new service
- ☐ An outreach service from residential care facilities
- ☐ Other, please specify:

If your services are linked to other services, please give details:

FORM 2
REGISTRATION CERTIFICATE
OF COMMUNITY-BASED SERVICES

DEPARTMENT OF SOCIAL DEVELOPMENT
PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008
(ACT NO. 70 OF 2008)

Registration Certificate No. _____

Issued to (name Of Community-Based Services)

It is hereby certified that the above-mentioned Community-Based Service situated at
(physical address and beneficiaries)

has been registered in terms of section 13 of the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) to deliver community-based services to
.....
.....beneficiaries.

This certificate is valid with effect from _____ (dd/mm/yyyy)
until.....

This certificate is issued in terms of section 6 of the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) and is not transferable.

(OFFICIAL STAMP)

HEAD OF DEPARTMENT

DATE:

PLACE.....

FORM 3**APPLICATION FOR REGISTRATION OF A TREATMENT CENTRE OR HALFWAY HOUSE IN TERMS OF THE PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008 (ACT 70 OF 2008)**

The following documents must be attached to the application for registering the treatment centre:

1. A copy of the constitution of the facility
2. Recommendation and Health Clearance Certificate from Local Authority
3. Local Authority building plans/schematic sketch of building
4. Detailed treatment programme
5. Daily programme (daily, weekly and monthly)
6. House rules for residents
7. Admission criteria
8. Financial statements (for the past 6 months)/projections
9. Means test
10. Medical and psychiatric treatment policy
11. Management structure and staff component
12. Nutritional programme
13. Fees structure

**PART A
IDENTIFYING PARTICULARS OF FACILITY****1. Name of proposed/existing facility**

Address

Tel:

Fax:

E-mail address:

Emergency number:

Registration number of company/NPO number

2. In which area is/will the facility be built/ operating?

3. Has the site already been acquired for the said facility? If this has not been acquired the applicant must provide full details of the site to the Department when such a site is acquired.

4. Buildings

4.1. Physical structure (building)

4.2 Location of the facility (area)

4.3 Name, address of the developer (if applicable)

4.4 Will there be any other buildings and/or activities on the site other than the proposed facility? If so, provide details:

5. Provide details of other registered facilities, in your area.

NAME OF FACILITY

**DATE OF
REGISTRATION**

**REGISTRATION
NR**

**LOCATION NUMBER OF
BEDS**

PART B**SITUATION ANALYSIS**

6. State how the number of beds was determined:

(Use separate sheet if necessary)

7. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

(Use separate sheet if necessary)

8. What clinical disciplines are/will be practiced in the facility?

(Use separate sheet if necessary)

9. What is the extent of the present demand for the services that is/will be provided?

(Use separate sheet if necessary)

10. How will/does the facility meet the demand for such service?

(Use separate sheet if necessary)

11. Have you taken into account existing private and public facilities in your calculation and projections. If yes, how?

(Use separate sheet if necessary)

12 Any other information deemed necessary for this application

(Use separate sheet if necessary)

PART C

PATIENT PROFILE

13. Number of residents for which registration is required:

ADULTS CHILDREN (under 18 years)_____

Male Females Male

Female_____

In-
patient_____

Hostel/Houses _____

TOTAL

14. Will you provide out-patient services? If Yes, supply details

(Use separate sheet if necessary)

15. Treatment period

Time Frame

Short Term (6 weeks)

Long term (6 weeks +)

Re-admission

16. Specify special programmes for long term treatment e.g. education;

Skills training;

17. What arrangements are being made with reference to detoxification?

18. Specify the dependence producing substance applicable to patients treated at the treatment facility

**ADULTS/
CHILDREN** _____

Male/ Female _____

Alcohol _____

Dagga _____

Mandrax _____

Heroin _____

Cocaine _____

Crack _____

Ecstasy _____

LSD _____

Inhalants _____

**Prescription
drug** _____

Other(specify) _____

PART D

19 MANAGEMENT STRUCTURE

PORTFOLIO NAME ADDRESS &CONTACTDETAILS

PROFESSION QUALIFICATION AND EXPERIENCE

Chairperson _____

Vice-
chairperson _____

Treasurer _____

Secretary _____

Auditors _____

Other _____

PART E

20 Personnel

Provide a detailed list of your staff established containing the following information:

NAME PROFESSION NAME OF BOARD/COUNCIL**&****REGISTRATION****NUMBER****SALARY FULL TIME PART-TIME**

The applicant hereby applies for registration as a Treatment Centre/Halfway House in terms of the Prevention and Treatment of and Prevention for Substance Abuse Act, 2008

SIGNED BY CHAIRMAN OF THE APPLICANT:**FULL NAMES AND SURNAME:****SIGNATURE:****DATE:**

WITNESSES (BOARD MEMBERS)

FORM 4
REGISTRATION CERTIFICATE
OF TREATMENT CENTRE/HALFWAY HOUSE

DEPARTMENT OF SOCIAL DEVELOPMENT
PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008
(ACT NO. 70 OF 2008)

Registration Certificate No. _____

Issued to (name Treatment Centre or Halfway House)

It is hereby certified that the above-mentioned Treatment Centre or halfway house situated at
(physical address and beneficiaries)

has been registered in terms of section 6 of the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) to deliver services related to substance abuse to
.....
.....beneficiaries.

This certificate is valid with effect from _____ (dd/mm/yyyy)
until.....

This certificate is issued in terms of section 6 of the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) and is not transferable.

(OFFICIAL STAMP)

HEAD OF DEPARTMENT

DATE:

PLACE:

FORM 5**APPLICATION FOR REGISTRATION OF OUT-PATIENT SERVICES****PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008 (ACT
NO 70 OF 2008)****(For an applicant that is an organization)**

_____ (full name of organization) herein
represented by _____ (full names and identity number),

in his or her capacity as _____ duly
authorized in terms of resolution no _____ dated _____ (attach a certified
copy of the resolution)

OR**(For an applicant that is an individual)**

_____ (full names and identity number of
individual applicant),
apply for registration of the services listed in section B hereof.

Section A: Basic details of the Service Provider (Organization or individual)**1. Name of**

Organization/Individual _____

2. Registration number (if applicable)

b. Non Profit Organizations number (if

any): _____

c. Company or trust registration number (if

any): _____

d. Any other registration details

(specify): _____

e. Has your registration ever been suspended or cancelled:

☐ YES/NO

If yes, please provide details:

3. Address details**3.1 Physical and postal address of Administration Office:**

3.2 Physical addresses and telephone numbers of service locations (identify facility)

- (i) _____ postal code _____
- (ii) _____ postal code _____
- (iii) _____ postal code _____
- (iv) _____ postal code _____

(If there are more service locations please attach a list)

4. Financial details**4.1 Do you have a bank account?****YES/NO**

If yes, provide following details

(ii) Bank:

Account name:

Type Account:**Account no:**

Branch Code:

4.2 Do you have an auditor?**YES/NO**

If yes, provide details

(iv) Name:

(v) Address :

(vi) Telephone

number: _____

4.4 Audited Financial Statements

Please attach a copy of your Audited Financial Statements for the past six months. If you do not have Audited Financial Statements please give the reasons therefore and attach financial reports.

5. Governance Details

3.3 Constitution: Please attach a certified copy.

3.4 Details of Governing Body:

Please attach a list of members of your organization with names and identity numbers. Please disclose and provide details of family interests or relationships pertaining to the organisation and staff:

5.3 Do you hold General Members Meetings

YES/NO

If yes, attach a copy of the minutes of the last meeting

4 ASSOCIATION WITH REGISTERED IN-PATIENT TREATMENT CENTRE

4.1 Are you linked to an in-patient treatment centre?

4.2 If not, why not. Provide

reasons:.....
.....
.....
.....
.....

4.3 What is the name of the in-patient treatment

centre?.....

4.4 Physical address of in-patient treatment

centre?.....
.....

4.5 Contact details of the in-patient treatment centre:

Phone:.....
.....

Fax:.....
.....

Email.....
.....

6.6 What is the nature of your association to the in-patient treatment

centre?.....
.....
.....

.....

.....

7. Beneficiaries

How many persons benefit from the services provided?

Declaration

I declare that the above information is true and correct. I understand that any misrepresentation or omission of pertinent information may be considered as sufficient grounds for withdrawal of registration.

Signature

Place

Date

Full Name:

Capacity:

Copy of ID to be attached

Section B: Community-based out-patient treatment services

5 Name of applicant (as in section A)

(iii) Organisation or Company:

(iv) Individual :

6 **Description of Community -based out-patient treatment services**

6.1 When was the services first established : (date)

6.2 **What services are rendered (please tick) (Attach copy of your services plan**

- ☐ Awareness raising
- ☐ Substance abuse educational programmes
- ☐ Transport
- ☐ Life skills programme
- ☐ Early Intervention
- ☐ Referrals
- ☐ Treatment
- ☐ Aftercare + re-integration
- ☐ Family support services
- ☐ Marriage enrichment services
- ☐ Statutory services
- ☐ Recreation

- ☐ Income Generation
- ☐ Socialisation
- ☐ Culture and Spiritual
- ☐ Home visits
- ☐ Advice
- ☐ Group Support
- ☐ Education and Training
- ☐ Counselling (social work)
- ☐ Temporary accommodation
- ☐ Other, Please specify

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

6.3 On how many days or hours per week do you operate? Tick

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Does the service operate over weekends and public holidays?

7 Beneficiaries

Please give a breakdown of persons who benefit from the services on a weekly basis

(iii) Total Number of persons:

(iv) Prevention/early intervention/treatment/aftercare + reintegration

8 Funding of the Services

8.1 Do you receive a grant/ subsidy from the Department of Social Development

YES / NO

If yes, what amount do you receive on a monthly basis:

R _____?

8.2 Do you receive a grant from the local authority

YES / NO

If yes, what amount do you receive per month or per annum:

R _____?

Have you applied for funding from the Department of Social Development which was turned down?

YES/NO

If yes give details:

Do beneficiaries pay for the services

YES / NO

If yes what do beneficiaries pay for the services per month/per day/per hour R
_____ per individual?

If no, please give your reasons:

5. Human Resources

Do you have paid staff members

YES / NO

Do you have volunteers?

If so, how many?

Do you pay transport costs of volunteers?

If yes, give breakdown of employed staff and volunteers:

POSITION	NO	TASKS

If you do not use paid staff members, how do you render the services?

(c) Volunteers

YES/NO

(d) Partnership workers, provided by other organizations

YES/NO

How many volunteers on a monthly basis render services _____ and the estimated total hours of volunteer work _____?

6. Service Locations

Provide a list of places and areas where services are rendered.

AREA	PLACE
(i)	
(ii)	
(iii)	
(iv)	
(v)	

If you render services at more locations please attach a list.

Provide sketch plans of the above facilities

8.3 Facilities in service delivery (please tick):

- ☐ Hall
- ☐ Offices
- ☐ Kitchen
- ☐ Store Room
- ☐ Dining Room

- ☐ Clinic
- ☐ Library
- ☐ Bathrooms/showers
- ☐ Toilets
- ☐ Wash Basins
- ☐ Other (specify)

If you do not have the above facilities at your disposal, how do you render the services?

Give details:

Basic amenities and equipment to render services:- Please tick below

- ☐ Kettle or urns
- ☐ Stove
- ☐ Fire
- ☐ Fridge
- ☐ Water supply
- ☐ Power supply
- ☐ Catering utensils
- ☐ Plates, cups etc
- ☐ Tables and chairs

- ☐ Recreation equipment
- ☐ Primary Health Care equipment
- ☐ Assistive devices (wheel chairs, tripods, commodes, walking sticks)
- ☐ Other, provide list:

Please attach a list of the equipment used in the facility

7. Business Plan

Do you render your services according to a business plan?

YES/NO

If yes, please attach your business plan to section B

If no, please indicate the reasons below:

- ☐ A new service
- ☐ An outreach service from residential care facilities
- ☐ Other, please specify:

If your services are linked to other services, please give details:

FORM 6
TEMPORARY REGISTRATION CERTIFICATE
OF COMMUNITY-BASED SERVICE

DEPARTMENT OF SOCIAL DEVELOPMENT
PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008
(ACT NO. 70 OF 2008)

Temporary Registration Certificate No. _____

Issued to (name of Community-Based Service)

It is hereby certified that the abovementioned Community-Based Service situated at:
(Physical address and capacity)

has been registered in terms of section 14 of the Prevention of and Treatment for Substance abuse Act, 2008 (Act No. 70 of 2008), subject to the following conditions:

Conditions:

This certificate is valid for a period of six months with effect from _____

(dd/mm/yyyy) to _____ (dd/mm/yyyy).

NB. This certificate is issued in terms of section 14 of the Prevention of and Treatment for Substance Act, 2008 and is not transferable.

HEAD OF DEPARTMENT

DATE:

PLACE.....

(OFFICIAL STAMP)

FORM 7**APPLICATION FOR FINANCIAL ASSISTANCE****PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008****(ACT NO.70 OF 2008)**

I, _____ (full names and surname) on behalf of _____ (organisation's name and NPO number, hereby applies for a financial award referred to in section 7(1) of the Prevention of and Treatment of Substance Abuse Act, 2008 (Act no.70 of 2008)

I provide the following services to (number) _____ persons (see attached list) at the place _____ known _____ as _____

_____ situated _____ at _____ (physical _____ address)

Service provided	
Registration number:	
Date of establishment of service:	
Number of staff delivering service (Attach register of names)	

Number of beneficiaries (Attach register of names)			
Physical address			
Postal address			
Telephone No e-mail Cell No		Fax	

I declare that the above information is true and correct. I understand that any misrepresentation or omission of pertinent information may be considered as sufficient grounds for rejecting the application.

Signature of

applicant _____ **Place** _____ **Date** _____

Documents to be attached to the form

- Business plan of organization and a list of services rendered by organization
- Names and certified copies of ID of members of the organization
- Constitution of the organization
- NPO registration certificate, if registered as an NPO
- Any other registration certificates or documents that can support the application
- Audited financial statements for at least six months
- Names and contact details of Auditors
- Background information on receiving previous financial awards

- Provide reference and contact details of persons / organizations supporting the application
- Disclose all sources of funding / income
- Register of list of beneficiaries
- Register of names of staff members rendering the services

FORM 8**APPLICATION FOR VOLUNTARY ADMISSION****Section 32 (1) of Prevention of and Treatment for Substance Abuse Act, 2008(Act No. 70 of 2008)****Name of rehabilitation centre/public/ private treatment centre where admission is desired:****Name of Treatment Centre:****Particulars of service user:****Surname:**.....

.....

First**Names:**.....

.....

.....

.....

.....

.....

Address:.....

.....

.....

.....

.....

.....

I am fully aware of the implications of Section 32(1) and (6) of Act 70 of 2008 and undertake to abide by the rules of the above named centre

.....

.....

Signed

Date:

To:

From:.....

.....

.....

.....

.....

.....

.....

1. I support the application and refer the person to you for treatment
2. the person can/ cannot contribute financially towards his/her residence and treatment
3. the following documents are attached:

(a) Medical certificate

(b) Social Report

(c) My reference number is.....

.....

.....

Social Worker

Date

Address:

FORM 9

**CONSENT FORM FOR APPLICATION ON BEHALF OF ANOTHER PERSON
[SECTION 32 (1) OF THE PREVENTION OF AND TREATMENT FOR SUBSTANCE
ABUSE ACT 70 OF 2008]**

NOTE

Where the consent of both parents is required, a separate form should be completed by each service user

**IN THE MATTER OF AN APPLICATION FOR ADMISSION
TO TREATMENT CENTRE OR HALFWAY HOUSE**

I,

_____ (full name),

Identity number: _____,

residing at _____

Being the parent or acting on behalf of service
user _____

(full name of child)

hereby voluntarily consent to the admission to treatment centre -

☐ (a) _____;
located at

(name of a treatment centre)

☐ (b) _____

(residential address)

Signature of parent or person acting on behalf of

service user

SIGNED BEFORE ME after I have explained to the said parent or person acting on behalf of service user as set out in section 32(1) of the Act, and have informed *him/her that –

- (i) *he/she may withdraw this consent in writing before a centre manager of the treatment centre at any time during a period of up to 60 days after having given this consent;

PLACE: _____

DATE: _____ Chairperson of Management

Structure

Insert an X in appropriate block and *Delete whichever is not applicable

FORM 10**AN APPEAL TO THE MINISTER OF SOCIAL DEVELOPMENT AGAINST A
DECISION OF THE DIRECTOR-GENERAL OF SOCIAL DEVELOPMENT IN TERMS
OF SECTIONS 19, 21, OF THE PREVENTION OF AND TREATMENT FOR
SUBSTANCE ABUSE ACT, 2008**

Name of appellant:

Name of in or out-patient centre

Physical address in or
appellant:

This is appeal against a decision of the Director-General of the Department of Social Development against the exercise of the Director-General's discretion in respect of a decision relating to:

Indicate decision against which this appeal is lodged (Indicate yes or no)	Grounds on which appeal is lodged
	Section 21: Consideration of application for registration of halfway house
	Section 19: Consideration of application for registration of treatment centre
	Section 19(4): Consideration of application for conditional registration
	Section 19(7): Consideration of application for renewal of registration
	Section 22(1): Consideration on which registration was granted
	Section 19(6) + 21(6): Cancellation of registration
	Other grounds of appeal

The reasons provided by the provincial head of social development for his or her decision are attached.

My reasons for appealing against the decision are attached hereto.

APPELLANT

DATE

NOTE: The appeal must be lodged with the Minister responsible for social development where the decision was taken by the Director-General.

FORM 11
APPLICATION TO TERMINATE OR WITHDRAW COMMUNITY-BASED
SERVICES
Section 14

DEPARTMENT OF SOCIAL DEVELOPMENT

**PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, 2008 (ACT
NO. 70 OF 2008)[Act]**

To: The Head of Department
Department of Social Development

Application is hereby made, in terms of section 14 (3) of the Act, to terminate or withdraw the following community-based services. The termination or withdrawal will take effect from.....

Service to be terminated or withdrawn _____

The reasons for the termination or withdrawal are—

Take further notice that as required in terms of section 14(3) of the Act, the following arrangements are being made to inform the service users and children in my/our care of the intended termination of the service.

It is our intention to refer the service users currently benefiting from our services to another service provider who provides similar services in the following area. _____

The details of the said service provider will be forwarded to the Department 30 days before the termination or withdrawal date mentioned above.

Details of organization/individual:

Name: _____

ID No.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Registration certificate No: _____

Physical address: _____

Postal address: _____

Tel. No. _____ Fax No. _____

Cell No. _____ E-mail address _____

List of beneficiaries, names, addresses and ID numbers

I undertake to fulfil any obligations in terms of the Act before the date of termination or withdrawal.

COMMUNITY-BASED SERVICE PROVIDER

Name:

Capacity:

Date:

FORM 12**NOMINATION FORM FOR CANDIDATES TO BE APPOINTED AS MEMBERS OF
THE MANAGEMENT STRUCTURE FOR COMMUNITY-BASED
SERVICES/TREATMENT CENTRE/HALF WAY HOUSE**

Each nomination must be lodged with the relevant community-based centre/treatment centre/halfway house by post, fax or hand before.....

Nomination forms are available at www.socdev.gov.za or directly from the community-based centre/treatment centre/halfway house requesting nominations.

A nomination which does not comply with the above requirements or which has not been lodged with the community-based centre/treatment centre/halfway house at the address stated below by the said date is invalid.

REQUEST FOR NOMINATIONS

1. In terms of the provisions of Regulation 33 of the Regulations made in terms of the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) nominations are hereby invited for candidates to be appointed by the community-based centre/treatment centre/halfway house to serve on the management structure.
2. Nominations are invited for the appointment of persons nominated by organizations in the social development sector and by the public.
3. Candidates appointed must comply with the qualifications set out in the Regulations.

4. Each candidate must be nominated separately in the following form:

NOMINATION FORM

I nominate (print the full names and surname of the candidate)

.....
.....
.....

for nomination as candidate to be appointed by community-based centre/treatment centre/halfway house as a member of the management structure.

Signature of person nominating

.....

Print full names and surname

.....

- (2) Each person who signs a nomination form must lodge a declaration in the following form with the nomination:

DECLARATION BY PERSON WHO SIGNS NOMINATION

I (print full names and surname)

.....

declare that I am resident in the Republic at state full residential address)

.....

.....

.....

.....

.....

SIGNATURE OF PERSON NOMINATING

I certify that the deponent has acknowledged that he/she knows and understands the contents of this declaration. Sworn to / affirmed and signed before me at

..... on 20.....

.....

COMMISSIONER OF OATHS

Office held

- (3) Simultaneously with the lodging or not later than the date determined in subparagraph (4), each candidate must lodge with the Minister-
- (a) A curriculum vitae of not more than 150 words, including, where possible, a telephone and fax number where the candidate may be reached;
 - (b) Passport photograph on which the candidate's name is indicated on the back;
 - (c) His or her consent to the nomination in the following form:

CONSENT TO NOMINATION

I (print full names and surname)

.....
.....

declare that-

- (a) I consent to nomination;
(b) I am permanently resident in the Republic at (state full residential address)
.....
(c) I agree to accept the nomination.

.....
SIGNATURE OF NOMINEE

I certify that the deponent has acknowledged that he / she knows and understands the contents of this declaration. Sworn to / affirmed and signed before me at on 20....

.....
COMMISSIONER OF OATHS

Office held

- (4) Each nomination shall be lodged with the Community-Based Centre by post, e-mail, fax or hand before
- (5) A nomination which does not comply with the above requirements or which has not been lodged with the Community-Based Centre at the address stated below by the said date is invalid.

FORM 13

**TRANSFER AND RE-TRANSFER OF SERVICE USERS FROM TREATMENT
CENTRES
PREVENTION OF AND TREATMENT FOR SUBSTANCE ABUSE ACT, NO 70 OF
2008**

Department of Social Development/Service Provider reference number:

Court reference number:

1. IDENTIFYING PARTICULARS

Particulars of the service user
Name

ID number:.....

Particulars of the current institution
Name

ID number:

Current residential address of institution

Current postal address of institution

Court where the court order was initially issued:

Court order issued in terms of which section of Act?

2. MOVEMENT OF A SERVICE USER (Provide information where applicable).

2.1) Retransfer to health establishment

Effective date of transfer: _____

Provide reason(s) for the transfer:

Name and residential address of treatment centre

Postal address of treatment centre

2.2) Retransfer to prison

Effective date of transfer: _____

Provide reason(s) for the transfer:

Provide reason(s) for the retransfer:

Name of the CYCC

Residential address

Postal address

2.4) Re-transfer to alternative care centre

Date for finalization of the retransfer: _____

Name of service user

ID number

Residential address

Postal address

FORM 14**Release of service user on license (section 4) (1)
Act for the Prevention and Treatment for Substance Abuse Act, No 70 of 2008**

Ref No:TO:

1. On the recommendation of the Management of the Treatment Centre:....., the Director-General has approved your release on license in terms of Section 47 (1) of Act 70 of 2008 as from _____
—until—on condition that you:
- (a) remain under the supervision of the Social Worker, to whom you must report forthwith (within 14 days) and with whom you must co-operate at all times;
 - (b) will not leave the above-mentioned address without informing your supervisor;
 - (c) will remain from the use of alcohol/drugs;
2. Should you fail to comply with any of the foregoing conditions, the Management may revoke the license and recall you
3. This license can be altered at any time without the furnishing of reasons.

MANAGER OF THE TREATMENT CENTREDATE:
