



HHR
HEALING HORIZONS REHAB

TUE 24 MARCH

2026



CONTACT US ON

 063 821 4650 • 072 215 0256 - 015 151 0816

 www.healingh.co.za

 Admin@healingh.co.za

 142 Suid Street, Polokwane, Limpopo

APPLICATION
FORM

SECTION A: APPLICATION FORM

1. Program Selection

Please select the program you are applying for (tick one):

- HHR Disciplinary Program Only
- HHR Rehabilitation Program Only
- Combined Rehab + Disciplinary Program

Your selection will determine the care plan, treatment duration, and fee structure that applies to your case.

2. Personal Information:

- Full Name: _____
- Date of Birth: _____
- Gender (Circle one): Male / Female / Other
- ID/Passport Number: _____
- Nationality: _____
- Contact Number: _____
- Email Address: _____
- Home Address: _____
- Emergency Contact Name: _____
- Emergency Contact Number: _____
- Relationship to Emergency Contact: _____

3. Parent/Guardian Information:

- Parent/Guardian Full Name: _____
- Relationship to Applicant: _____
- Contact Number: _____
- Email Address: _____

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- Home Address (if different from above): _____
- Is the parent/guardian aware of the substance abuse? (Circle one): Yes / No
- Suspected drug(s) taken: _____

Has the parent/guardian attempted any interventions previously? (Circle one): Yes / No • If Yes, provide details: _____

4. Who will be responsible for payment of the treatment?

(Tick one):

Parent/Guardian

Medical Aid

Other (please specify): _____

5. Substance Use History:

- Primary Substance of Addiction: _____
- Other Substances Used: _____
- How long have you been using the primary substance? _____
- Last time you used the substance(s): _____
- Have you undergone treatment before? (Circle one): Yes / No
 - If Yes, when and where: _____
 - What was the outcome? _____

6. Medical History:

- Do you have any current medical conditions? (Circle one): Yes / No
 - If Yes, please describe:
- Are you currently taking any prescribed medications? (Circle one): Yes / No
 - If Yes, please list medications:
- Have you ever been hospitalized due to substance abuse or related medical conditions? (Circle one): Yes / No
 - If Yes, provide details:
- Do you have any known allergies? (Circle one): Yes / No
 - If Yes, please list allergies

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7. Chronic Medical Conditions & Medication

- Do you have a chronic condition such as Epilepsy, Schizophrenia, HIV, ADHD, or any other requiring ongoing medical care? (Circle one): Yes / No
- If Yes, please specify condition(s): _____
- Are you currently taking prescribed chronic medication? (Circle one): Yes / No
- If Yes, please list medications: _____

8. Treatment Phases:

At Healing Horizon Rehab, our treatment consists of four structured phases. Please read through each phase and confirm your understanding by ticking the boxes. Treatment phases may not be offered in numerical order, but they can be mixed on a case by case bases.

Not all skills development courses will offer academic certificates, but they can be offered completion certificates from the center.

Phase 1: Detoxing Phase

- Objective: Safely detoxify the body and stabilize basic functions like sleep and appetite to prepare for deeper therapeutic engagement.
- I understand the purpose of Phase 1.

Phase 2: Therapeutic Phase

- Objective: Engage in individual and group therapy to address the psychological and emotional issues related to substance abuse.
- I understand the purpose of Phase 2.

Phase 3: Physical Training Phase

- Objective: Rebuild physical strength and confidence through structured activities, including military drills and sports, to enhance discipline.
- I understand the purpose of Phase 3.

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Phase 5: Reintegration and Reflection (2 weeks)

- Objective: Summarize the entire treatment process and create a plan for maintaining recovery, focusing on reintegration into daily life and building healthy habits.
- [] I understand the purpose of Phase 5.

9. Prohibited Items

Food:

- *Reason:* The facility prohibits bringing outside food to minimize the risk of food poisoning, allergic reactions, or contamination. Purchasing food from the facility ensures that all meals and snacks meet strict health and safety standards.

Toiletries:

- *Reason:* Outside toiletry products are not allowed, as some items may contain concealed contraband or substances that could harm the patient or others. The facility provides approved toiletry items to ensure safety and compliance with regulations.

Cash:

- *Reason:* To prevent theft, bribery, or misuse of money within the facility, cash is strictly prohibited. Families must deposit funds into the facility's bank account for secure handling and proper allocation.

Permitted Items

Clothing:

- Patients are allowed to bring a *limited* amount of clothing suitable for their stay. Excessive luggage may be discouraged to maintain cleanliness and avoid cluttering in living spaces.

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Facility Store Benefits

Controlled Environment:

Purchasing from the facility store reduces the chances of prohibited items being smuggled in, ensuring a secure environment for all patients.

Convenience:

Parents can rest assured that their loved ones have access to approved, high-quality food and toiletries without the need to bring outside items.

Safety First:

This policy helps to eliminate potential risks associated with bringing outside items, such as exposure to allergens, harmful chemicals, or concealed drugs.

Money Management:

- Families are encouraged to deposit funds into the facility's official bank account. These funds can be used for:
 - Purchasing food, toiletries, or other approved items from the facility store.
 - Covering any additional approved expenses during the patient's stay.
- Important: Parents and families are *strictly prohibited* from giving cash to patients or staff to prevent misuse or illegal activities.

- **Family Involvement:**

- Are the family members willing to participate in family therapy? (Circle one): Yes/No
- Do the family members have any concerns about the treatment process? (Circle one): Yes / No
 - If Yes, please describe:
- How does the applicant's addiction affect family dynamics?

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10. FEE STRUCTURE

Please note: Admin/Registration fees are **not included** in the monthly rates.

Rehabilitation + Disciplinary Program

A. STANDARD CARE (NON-CHRONIC PATIENTS)

- Monthly Fee: R3,800

Upfront First Payment (Month 1):

- Monthly Fee: R3,800
- Registration Fee: R1,500 (once-off)
- Bed & Sheets: R900 (once -off)
- Medical Assessment: R500 (once-off)
- Flushing Drip: R320 (once-off)
- Storage: R500 (once-off)

Total First Month Payment: R7,520
From Month 2 Onwards: R3,800 per month

B. CHRONIC CARE (PATIENTS ON CHRONIC MEDICATION / EXTRA CARE CONDITIONS)

(Applies to Epilepsy, Schizophrenia, HIV, ADHD, and other chronic conditions requiring ongoing care)

- **Monthly Fee: R5,000**

Upfront First Payment (Month 1):

- Monthly Fee: R5,000
- Registration Fee: R1,500 (once-off)
- Bed & Sheets: R900 (once -off)
- Medical Assessment: R500 (once-off)
- Flushing Drip: R320 (once-off)
- Storage: R500 (once-off)

Total First Month Payment: R8,720
From Month 2 Onwards: R5,000 per month

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Disciplinary Program Only

- 30 Days – **R4,000**
- 3 Months – **R3,400 per month**
- 6 Months – **R3,000 per month**

Free Starter Kit Includes:

- Round neck T-shirts: 2
- Golf shirts: 2
- Caps: 2

Items to bring along

- One blanket
- One Duvet cover
- One Pillow
- 4 T-shirts
- 3 track pants
- One pair of jeans/chino pants
- One shirt
- 2 pairs of tekkies
- One sleeper
- One sandle
- 2 jerseys
- 3 Pair of socks
- Underwear as per your choice
- Bible
- Bank card
- 60 eggs (to be delivered every month)
- 12 × 400g tins of pilchards **OR** 12 × 400g tins of baked beans (to be delivered every month)
- **NO COSMETICS ALLOWED** (This includes items such-as: roll-ons, perfumes, deodorants, lotions, body sprays, Vaseline, makeup, hair food, hair gel, etc)

- Pricing is subject to periodic adjustment in response to economic conditions.
- A 30-day prior notice will be communicated to all parents before implementation.
- Promotional prices may be reviewed and adjusted periodically.

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IMPORTANT NOTE:

Only clothing items are allowed in the center.

- Toiletries, snacks, and food are not permitted.
- No other items, except for small packages of clothing, will be accepted. The center has an in-house tuck shop that provides everything needed.

SECTION B: CONSENT FORM

Combined Rehab + Disciplinary Program

A. HHR Rehab Program (If selected)

I understand that the **HHR Rehab Program** is an 8-month structured recovery plan consisting of five key phases:

1. **Detoxing Phase** – Stabilization and safe withdrawal
2. **Therapeutic Phase** – Individual and group therapy
3. **Physical Training Phase** – Rebuilding confidence and discipline
4. **Reintegration Phase** – Planning for sober, independent living

I voluntarily agree to participate in all phases and understand that **detox is only the beginning** of a longer recovery process.

I consent to:

- Physical examinations and medical assessments
- Administration of prescribed medications
- Emergency medical intervention if needed
- Monitoring of my health and withdrawal symptoms

I acknowledge that I have been informed of the possible side effects of detoxification (e.g., nausea, headaches, anxiety), and that **detox does not guarantee full recovery**.

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B. HHR Disciplinary Camp (If selected)

I understand that the **HHR Disciplinary Camp** is a behavioral correction and personal development program that includes:

- Early wake-up routines and structured schedules
- Supervised physical activities, military-style drills
- Rules and discipline-based responsibilities
- Positive behavior reinforcement and emotional maturity training

I agree to fully participate and follow all rules, acknowledging that failure to comply may result in disciplinary action or dismissal from the camp.

I confirm that I am medically fit to engage in physically demanding activities and have disclosed any medical conditions.

POPIA Consent

(Protection of Personal Information Act – Section 11 & 12)

I grant permission to **Healing Horizon Rehab (HHR)** to use photographs or videos of me for **awareness and marketing purposes**, including social media. I understand that:

- My image will not be used in a defamatory or exploitative way
- Consent can be withdrawn in writing at any time
- HHR will comply with **POPIA regulations**

Confidentiality Agreement

I understand that all personal and medical information shared during my stay at HHR will be kept **confidential**, unless required by law or unless I give written permission for it to be shared.

Commitment & Financial Responsibility

By signing this form, I understand:

- My space in the program is reserved upon registration.
- If I **voluntarily withdraw** or am **dismissed** for non-compliance, I remain **financially responsible for the full duration** of the program selected.
- No refunds will be issued without prior agreement.

Patient Signature: _____

Date: _____

Witness Name (Staff): _____

Witness Signature: _____

Date: _____


Emergency Contact Name: _____

Emergency Contact Number: _____

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SECTION C: TRAVEL CONSENT FORM

To be completed by the parent/guardian. (Only when pick up is made by the center)

This form must be completed and signed by the legal guardian or responsible party to authorize the transportation and care of the patient from their home to **Healing Horizon Rehab (HHR)**

I understand and agree to the following terms:

1. Transportation and Charges

- I authorize the transport of the patient by **Healing Horizon Rehab (HHR)** staff from their home address or agreed-upon pickup point to the facility.
- I acknowledge that an additional transportation fee of **R9.00 per kilometer** will apply to cover the distance from the pickup location to **Healing Horizon Rehab (HHR)** and for any return trips as necessary.
- I understand that this transportation fee will be added to the patient's account, payable by the guardian or party responsible.

2. Safety and Responsibility

- I understand that **Healing Horizon Rehab (HHR)** staff will take reasonable measures to ensure the safety and comfort of the patient during transportation and arrival at the facility.
- I acknowledge that the staff is authorized to make necessary arrangements to ensure the patient's well-being and to address any unexpected medical or behavioral needs that may arise during transport.
- I understand that, if necessary, reasonable force may be applied to ensure the safety of the patient and others during transport. This will only occur if the patient exhibits behavior that poses a risk to themselves or the staff

3. Limitation of Liability

- I release **Healing Horizon Rehab (HHR)**, its staff, and affiliates from any claims or liability arising from unforeseen incidents during the transportation of the patient, provided that all actions taken were within the bounds of reasonable care.
- I agree to notify **Healing Horizon Rehab (HHR)** of any special medical or behavioral considerations for the patient that could impact their safety or require specific accommodations during transport.

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4. Agreement on Personal Belongings

- I acknowledge that the patient may only bring necessary personal items approved by the facility, and I agree that no valuables, cash, or unauthorized items will be transported to the center with the patient.
- I understand that any prohibited items brought to the facility will be collected and secured by the staff upon arrival, and arrangements for their return will be made as deemed appropriate by the facility.

Acknowledgment and Signature

By signing this form, I confirm that I have read and fully understand the terms and conditions outlined above. I consent to the transportation and care of the patient as specified, and I accept the associated charges.

- Parent/Guardian's Full Name: _____
- Guardian's Signature: _____
- Date: _____

Healing Horizons Rehab Staff Signature (Upon Pickup):

- Staff Name: _____
- Staff Signature: _____
- Date and Time of Pickup: _____

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SECTION D: POST-DETOXIFICATION CONSENT FORM

This form is intended to obtain the patient's informed consent to continue treatment at **Healing Horizon Rehab (HHR)** after successfully completing the detoxification process.

Purpose of This Consent Form

After detoxification, patients may require further therapeutic care and support to achieve full recovery. By signing this form, the patient consents to remain in the rehabilitation program and continue the agreed- upon treatment plan at Healing Horizon Rehab (HHR), recognizing that the facility is committed to their holistic recovery journey.

Terms of Continued Treatment

Voluntary Continuation: I, the undersigned, confirm that I am in a stable and clear state of mind and voluntarily consent to stay at **Healing Horizon Rehab (HHR)** for further treatment and rehabilitation.

Program Structure: I understand that my continued stay will involve participation in the program's structured phases, including therapeutic, physical training, skills development, and reintegration support.

Agreement to Facility Rules: I acknowledge that I will comply with all rules and regulations at **Healing Horizon Rehab (HHR)**, including any updates or changes to ensure a safe and effective recovery environment.

Right to Withdraw: I am aware that I have the right to discuss my treatment plan with my assigned counsellor and may withdraw from the program if deemed appropriate, upon consultation with the program's care team and my guardians.

Financial Agreement: I understand that any costs associated with continued care are my responsibility and that my guardian or designated payee will ensure timely payment.

Privacy and Confidentiality: I understand that all aspects of my treatment are confidential and that my privacy will be respected in line with Hub's policies.

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SECTION D: INDEMNITY FORM

I, hereby acknowledge that I am the parent/guardian of..... who is being admitted to Healing Horizon Rehab (HHR) Centre for treatment and rehabilitation.

I understand that the centre will provide a safe and supportive environment for my child's treatment, but I acknowledge that there are risks associated with the treatment and rehabilitation process.

In terms of Section 39 of the Constitution of the Republic of South Africa, 1996, and the principles of delictual liability as set out in the South African common law, I hereby indemnify and hold harmless Healing Horizon Rehab (HHR) its employees, agents, and affiliates, against any and all claims, demands, or causes of action that may arise from any damage, loss, or injury to my child or property, including but not limited to:

- Any sickness, illness, or medical condition that may arise during or after treatment
- Any escape or unauthorized departure from the center
- Any death or injury that may occur during or after treatment

I understand that the center is not responsible for any of the above-mentioned events, and I hereby assume full responsibility for any and all consequences.

In terms of Section 55 of the Consumer Protection Act 68 of 2008, I acknowledge that I have been informed of the risks associated with the treatment and rehabilitation process, and I hereby accept those risks.

I further acknowledge that in the event of my child's escape or unauthorized departure from the center, I will remain liable for the monthly fees for the remaining period of treatment.

In the event of my child's death or sickness, I will not hold the center responsible, and I will remain liable for any outstanding fees.

I have read and understood the terms and conditions of this indemnity form, and I hereby sign it voluntarily.

Parent/Guardian Signature:.....

Date:.....

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SECTION E: HHR BANKING DETAILS

Nedbank limited (Monthly Program Fees)

Account Holder : Healing Horizon Rehab

Account Number :130-278-557-5

Branch code : 198765

Ref : Patient Name and Surname

- **Purpose:** This account handles payments for the primary rehabilitation and treatment services provided at the center, covering professional support, therapy, accommodations, and essential resources required for the patient's treatment journey.
- **Due Date:** All monthly fees must be received no later than the **2nd of each month**. Consistent payment ensures uninterrupted support and access to the necessary resources for recovery.

Am aware that I will be charged extra R500 for late payment after the 2nd of each month.

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Acknowledgment & Signatures

I, the undersigned, confirm that I have read, understood, and agreed to the terms and conditions outlined in this document. I acknowledge that the information provided is accurate and that I will comply with the policies and procedures of Healing Horizon Rehab (HHR).

Patient Details:

- Full Name: _____
- ID/Passport Number: _____
- Date: ____/____/____
- Signature: _____

Guardian/Next of Kin (if applicable):

- Full Name: _____
- Relationship to Patient: _____
- Contact Number: _____
- Date: ____/____/____
- Signature: _____

FOR OFFICE USE ONLY

Healing Horizon Rehab (HHR) Representative:

- Full Name: _____
- Position: _____
- Date: ____/____/____
- Signature & Official Stamp: _____

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