

**National Programme on**

**Reintegration of Stabilised Mental Patients of**

**the Brown Sequard Mental Health Care Centre**

EXPRESSION

OF INTEREST FROM RESIDENTIAL CARE HOMES

October 2022



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| CONTACT DETAILS | | | |
| **Name of Residential Care Home** |  | | |
| **Postal Address** |  | | |
| **Tel** |  | | |
| **Email** |  | | |
| **Website** |  | | |
|  |  | | |
|  | **Name** | **Email** | **Tel** |
| **President/Chairperson of Managing Committee/Board** |  |  |  |
| **Person responsible for day-to-day management of RCH** |  |  |  |

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| **RESIDENTS** | | |
|  | **Number of Residents** |
| **Actual** |  |
| **Capacity** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **HUMAN RESOURCES** | | | |
| **Catagory** | **Number Full Time** | **Number Part-Time** |
| **Technical Staff** (e.g., caregivers, medical and paramedical staff) |  |  |
| **Management and Administrative Staff** |  |  |
| **Other** *(Please specify)* |  |  |

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| TRACK RECORD |

|  |  |
| --- | --- |
| Number of years in operation |  |
| Whether licenced under the Residential Care Home Act | **Yes/No** |
| Whether currently accommodate any residents with mental illness | **Yes/No** |
| Whether have experienced staff to work with mentally ill patients | **Yes/No** |

**INTERVENTIONS UNDER THE NATIONAL PROGRAMME**

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| Indicate number of mental patients able to accommodate (maximum of 10) |  |
| Able to provide the following services:  o Appropriate care and residential services  o Giving medication to patients as may be prescribed  o Social and leisure activities, including outdoor activities in collaboration with NGOs  o Conveyance of patients to hospital in case of emergency | **Yes/No** |
| Agreeable to work with NGOs and provide access to NGO staff on premises for:  o Follow ups of patients  o Occupational therapy (twice monthly for a period of 12 months)  o Psychological support (twice monthly for a period of 6 months) | **Yes/No** |
| Allow family members to visit patients | **Yes/No** |
| Agreeable for carers/staff to be given necessary training including on the job training | **Yes/No** |
| Agreeable to submit regular feedback/reports on patients | **Yes/No** |

**DECLARATION FORM**

I, the undersigned, declare as the representative of < *Organisation Name*> that:

* All information given in this Expression of Interest is accurate.
* The organisation will provide any further information to the National Social Inclusion Foundation as and when required for the purpose of due diligence.
* The Expression of Interest has been approved by the Managing Committee/Board of the organisation.

|  |
| --- |
| Name |
| Position |
| Signed |
| Date |

*(Please affix seal of the organisation*)

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