EFFINGHAM CARE CENTER
PO Box 386
Springfield, Georgia 31329

The following applicant requests admission to the Extended Care Center:

Mr.
Mrs. _____ Current
Miss First Middle Last Address _____
_____

Age _____ Date of Birth _____ Sex ___ Place of Birth _____

Health status of Applicant _____

Contact Person(s)

Name _____ Relationship _____
Address _____ Phone _____
_____ _____

Name _____ Relationship _____
Address _____ Phone _____
_____ _____

Name _____ Relationship _____
Address _____ Phone _____
_____ _____

Financial Resources

Recipient Social Security # _____ $_____per month
Pension, Retirement or other income. _____ $_____per month
Other (Give Source) _____ $_____per month
(Please attach a copy of SS card, Medicaid card, Medicare card and any ins. cards that apply).

Medicare Information

Number _____ Hospital Benefits ( ) Medical Benefits ( ) Veteran Benefits ( )

Medicaid Information

Number _____

Hobbies and Interests _____
Religious Affiliation _____ Church _____
Name of Minister _____
Physician Name/Address _____
****PLEASE NOTE THAT APPLICANT MUST HAVE A PHYSICIAN WITH ADMITTING PRIVILEGES****

Has applicant ever been charged with a sex offense? Yes ( ) No ( )
Does applicant use tobacco products? Yes ( ) No ( )
Does the applicant smoke? Yes ( ) No ( )

Signed _____ Phone # _____
Applicant
Signed _____ Phone # _____
Person providing information for Applicant

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(Applicants eligibility for admittance is contingent upon facility review.)

Effingham Care Center is a tobacco free facility.

If any of the statements above have been falsified, the applicant is subject to removal from the facility without recourse.

Should you have any questions or need assistance, please do not hesitate to contact the Social Services Coordinator at (912) 754-0302.

Date submitted to facility_____

Thank You