❑ Glenn-Mor Nursing Home
P.O. Box 1739
Thomasville, GA 31799
(229) 226-8942

❑ Mitchell Convalesent Center
37 South Ellis Street
Camilla, GA 31730
(229) 336-8377

❑ Pelham Parkway Nursing Home
608 Dogwood Dr., S.E.
Pelham, GA 31779
(229) 294-8602

APPLICATION FOR ADMISSON

INSTRUCTIONS: Please answer all questions as accurately and completely as possible. All information will be held in strict confidence.

PERSONAL INFORMATION

Full Name	E-mail	Sex: ❑ Male ❑ Female
Home Address with State & Zip		Phone #

Date of Birth	Place of Birth	Marital Staus: ❑ Widowed ❑ Divorced ❑ Single ❑ Married ❑ Separated	Name of Spouse

Mother's Maiden Name	# of Children	# of Children Living	Medical Insurance: ❑ Medicare ❑ Medicaid ❑ Other: ___

Medicare #	Medicaid #	Social Security #	Monthly Income $	Monthly Pension Income $

List Your Living Children	Address of Your Living Children	Phone # - Home	Phone # - Work

List Other Close Relatives (relationship)	Address of Other Close Relatives	Phone # - Home	Phone # - Work

In Case of Serious Illness or Death, Notify	Address of Person(s) to Notify	Phone # - Home	Phone # - Work
E-mail			
E-mail			
E-mail			

PERSONAL HISTORY

Where have you lived most of your life?	Your Profession, Trade, or Occupation

Highest grade completed?	What are your hobbies?

Relationship with whom you are living now?	Current Address	Home Phone # ___ Work Phone# ___

Military Service? ❑ Yes ❑ No	If Yes, Describe	# of Years of Service ___ Rank

FUNERAL INFORMATION

Funeral Home	Address	Phone #
Church	Address	Phone #

ADMRECRD

PERSONAL HISTORY

Local Doctor:	Address:	Phone #:
Pharmacy:	Address:	Phone #:
Dentist:	Address:	Phone #:
Other Doctor:	Address:	Phone #:
Other Doctor:	Address:	Phone #:
Other Doctor:	Address:	Phone #:

Last Period of Hospitalization	Date	Location	Doctor	Illness

		Comments
Are you able to go about without assistance?	☐ Yes ☐ No	______
Can you dress yourself?	❑ Yes ❑ No	______
Have you ever been paralyzed?	❑ Yes ❑ No	______
Is there mental illness in your immediate family?	❑ Yes ❑ No	______
Can you care for your normal personal needs?	❑ Yes ❑ No	______
Do you have heart trouble?	❑ Yes ❑ No	______
Do you have cancer?	❑ Yes ❑ No	______
Do you have sores?	❑ Yes ❑ No	______
Do you have kidney trouble?	❑ Yes ❑ No	______
Do you have tuberculosis?	❑ Yes ❑ No	______
Do you have diabetes?	❑ Yes ❑ No	______
Do you have high blood pressure?	❑ Yes ❑ No	______
Have you ever been a patient in a mental hospital?	❑ Yes ❑ No	______

Diagnoses

I make this application for admission into this facility of my own free will and accord. I declare the answers to the foregoing questions to be true, full and complete. I further acknowledge I have been fully informed of services available in the facility and related charges including any charges not covered under Titles XVII or XIX of the Social Security Act, that I will be transferred or discharged only for medical reasons or for my welfare or that of other residents; that I will be encouraged to exercise my rights as a resident and as a citizen to voice my grievances to facility staff and/or outside representatives of my choice; that I may manage my personal financial affairs or be given, at least quarterly, an accounting of financial transactions made on my behalf should the facility accept my written delegation of this responsibility; that I will be free from mental and physical abuse, free from chemical and (except in emergencies) physical restraints except as authorized in writing by my physician; that I may approve or refuse the release of my medical record to any individual outside the facility; except in case of transfer to another healthcare facility or as required by law or third party payment contract and that my personal and medical records will be treated with the strictest rules of confidentiality; that I will be treated with consideration, respect and full recognition of my dignity and individuality, including privacy in treatment and in care for my personal needs; that I will not be required to perform services for the facility that are not included for therapeutic purposes in my plan of care; that I may associate and communicate privately with persons of my choice, may send and receive mail unopened, unless medically contraindicated as documented by my physician in my medical record; that I may retain and use my personal clothing and possessions as space permits; that, if married, I will have privacy for visits by my spouse. The approved monthly reimbursement rate established by the Department of Human Resources is an inclusive rate to cover the cost of the following: [a] resident's room and board (including special diet when specifically prescribed by a physician), privacy shall be furnished in case of terminal illness; [b] laundry (including personal laundry); [c] nursing and routine services, routine services include all nursing services and supplies, other supplies and equipment related to the day-to-day care of the resident, items of service which are covered in routine services include the following: all nursing services (excluding private duty nurses) regardless of the condition of the resident, medical social services, physical therapy, restorative nursing care, tray service, bed rails, walkers, wheelchairs, incontinency care and incontinency pads, hand feedings, special mattresses and pads, massages, syringes, enemas, nursing supplies and dressings (other than items of personal comfort or cosmetic items), extra linens, assistance in personal care and grooming, laboratory procedures not requiring laboratory personnel, non-prescription drugs to include aspirin, milk of magnesia, mineral oil, rubbing alcohol, prophylaxis medications (i.e. influenza vaccine, etc.). Physicians' services are not included. Prescription drugs are not furnished, but are obtained from a local drug store of the resident's choice.

______________________________ ______________________________

Signature of Responsible Party Date/Time Signature of Witness Date/Time