**Angel Wings Foundation Inc. Group Home**
www.angelwingsfoundationinc.com
121 E. Main Street, Moncks Corner, SC 29461 ● Phone: (843) 499-2729 ● Fax: (843) 688-4421
Email: info@angelwingsfoundationinc.com

**Instructions:**

- Fill out all requested information by printing or typing (except signatures).
- Attach pages if needed for additional information.
- Once complete, mail, fax, or scan and email application to the center.
- After receiving the application, the center will call and set up an appointment for a visit and for the applicant to be evaluated.

## Admission Application

Applicant Name_____
(Last) (First) (Middle)

Address_____
(Street/Apt.) (City) (State) (Zip)

Phone _____ Social Security # ____ - ___ - ____ Religion _____

Sex (circle) M F Age ____ Date of Birth ___ /___ /_____ Place of Birth (city/state) _____
(MM) (DD) (YYYY)

Parental state (circle) Involved/Terminated/Unknown Name of guardian (if living): _____

With whom does applicant live? _____ Relationship_____

Alternate emergency contact _____ Phone _____

Address_____
(Street/Apt.) (City) (State) (Zip)

**Applicant Health History**

List any major operations, chronic illnesses, and medical conditions _____

_____

_____

_____

Personal Physician _____ Phone _____

Address_____
(Street/Apt.) (City) (State) (Zip)

Preferred hospital _____

Pharmacy _____ Phone _____

(continue to next page)

**Admission pg. 2**

**Medicare/Insurance Information**

 Part A Claim # _____

 Part B Claim # _____

 Other insurance coverage _____

**Name** _____ What assistance is required in the following areas?

 Walking, Standing Explain _____

 Toileting _____

 Bathing_____

 Eating _____

**Dietary Requirements :**  Regular diet  Low sodium  Diabetic Other(please explain)

_____

_____

_____

_____

_____

_____

| Current Medications | Dosage | Times Given |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Is supervision or help required with medications? Yes / No Explain (if yes) _____
(circle)

**Admission pg. 3**

Requested starting date _____ Days: (circle) Monday Tuesday Wednesday Thursday Friday

Transported by Agency/Family/Other _____
(circle)

Transportation assistance required _____

What additional special needs does the applicant have? (i.e., need for socialization, supervision, etc.) _____

_____

Name, address, and phone number of individual or agency responsible for payment of child living care services

Name_____ Phone _____

Address_____
(Street) (City) (State) (Zip)

Applicant signature _____ Date _____

Signature of person completing this form _____ Relationship _____