

FOR OFFICE USE ONLY:	
Date Application Received:	_____
Probable Admission Date:	_____
Hooverwood Attending Physician:	_____
Resident #: _____	Room # _____
Qualifying Hospital Stay: _____	

INDIANAPOLIS JEWISH HOME, INC. HOOVERWOOD

“A TRADITION OF HEALTHCARE EXCELLENCE”

APPLICATION FOR ADMISSION

Dear Applicant:

We are pleased you are considering HOOVERWOOD to meet your nursing, rehabilitation, functional, and psycho/social needs.

Our Admissions/Social Services staff is available for pre-admission information, tours, and to answer questions you may have regarding level of care, room availability and cost.

Submission of this application will begin the admission process or place the applicant on the waiting list, depending on bed availability. **Copies of Medicare, Medicaid, other insurance cards (front and back), Social Security card and a picture ID are also requested.**

A completed application may be returned by any of the following methods:

- 1) in person, to the receptionist
- 2) by mail: Hooverwood, Attn: Admissions, 7001 Hoover Road, Indianapolis IN 46260
- 3) by fax: (317) 257-8423
- 4) by email: brettig@hooverwood.org

NAME OF APPLICANT _____

PERSONAL INFORMATION

Admitted from _____

Name _____ M F Mr. Mrs. Miss Married Widowed
(Please circle) Divorced Single

Current Address _____
Address City State Zip

Telephone # _____ Date of Birth _____ Age _____

Place of Birth _____ Primary Language _____ Military Service _____

Race _____ Spouse's Name _____ Deceased: Yes No

Religion _____ Synagogue/Temple/Church _____

IMPORTANT NUMBERS / INSURANCE CARDS

Please submit copies of both sides of Medicare, Medicaid, Supplemental insurance cards, as well as Social Security card and picture ID with application.

Medicare #: _____ Part A Effective: _____ Part B Effective: _____

Social Security #: _____

Part D Company: _____ Part D #: _____ BIN #: _____

Medicaid #: _____ Medicaid Case Worker _____
Name Phone

SUPPLEMENTAL INSURANCE POLICIES

Company: _____ Policy #: _____

Billing Address: _____
Address City State Zip

BILLING INFORMATION

Send Statements to: _____ Relationship: _____
Name

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

Primary payment source: Private Pay _____ Medicaid _____ Medicare _____

Secondary payment source: Private Pay _____ Private insurance _____ Medicaid _____

Application for placement is: Long Term _____ Short Term _____ Uncertain _____

LEGAL INFORMATION

**Power of Attorney for Finances
(Copy of Legal Document must be provided)**

Name: _____ Relationship: _____

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

**Health Care Representative / First Emergency Contact
(Copy of Legal Document must be provided. Provide copy of Living Will if applicable.)**

Name: _____ Relationship: _____

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

ADDITIONAL EMERGENCY CONTACTS

Please list contact people in order of priority.

Name: _____ Relationship: _____

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

Name: _____ Relationship: _____

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

Name: _____ Relationship: _____

Address: _____

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

I/We certify that the information provided in this application is true and correct to the best of my (our) knowledge.

Signature _____

Date _____

Signature _____

Date _____