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

INDIANAPOLIS JEWISH HOME, INC.

HOOVERWOOD

"CARING, FOR GENERATIONS℠"

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: crobinson@hooverwood.org

NAME OF APPLICANT _____

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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 <u>both</u> sides of Medicare, Medicaid, Supplemental insurance cards, as well as Social Security card and picture ID with application.

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

Medicare Replacement Plan:_____ Medicare Replacement Plan #:_____

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 ____

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SERVICE PROVIDERS/PREFERENCES

NOTE: Williams Brothers Pharmacy is used for all Medicare admissions.

Pharmacy Choice for long term: ____ Williams Bros. ____ Other (please specify) _____
Address: _____
Phone: _____ Fax: _____

Funeral Home: _____ Phone # _____

Hospital preference: _____

Primary Care Physician: _____ Phone # _____ Fax # _____

Physician's Address: _____

Other Physicians/Specialists:

Dentist	Phone #	Audiologist	Phone #
Podiatrist	Phone #	Cardiologist	Phone #
Opthomologist	Phone #	Neurologist	Phone #
Psychiatrist	Phone #	Other	Phone #

- Has Hooverwood provided you services in the past? Yes No (Please circle one)
- Has Applicant had any therapy this calendar year? Yes No (Please circle one) If yes, please indicate place and dates:

- List any hospitalizations or nursing home care received during the past **12 months.** (Please indicate place and dates):

Hospital Admission(s)/Discharge Dates	Nursing Home Admission(s)/Discharge Dates

****

CONFIDENTIAL FINANCIAL INFORMATION

Monthly Income Sources
Social Security: $ _____ Pensions, interest, other: $ _____

Assets
Checking Account: $ _____ Savings Accounts: $ _____

Investments, e.g. Stocks/Bonds: $ _____ Money Market/C.D.: $ _____

Other Assets: $ _____ Life Insurance: Whole ____ Term ____ Value: $ _____

Real Estate: $ _____ Beneficiary: _____

Total amount of assets: $ _____

- Over -

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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

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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_____

Revised 9/2012