ROSE HILL
5130 Rose Hill Blvd.
Holly, MI 48442-9507
Phone: 248.531.2405
Fax: 248.634.7754
rosehillcenter.org

Benefit / Contact Information

Applicant's Name: _____

Social Security Number: _____ Date of Birth: _____

THE FOLLOWING MUST BE COMPLETED FOR ADMISSION TO ROSE HILL CENTER

GOVERNMENT BENEFITS

Current Social Security Disability:

$ _____ Claim #: _____ Office: _____ Worker: _____

Current Supplemental Security Income:

$ _____ Claim #: _____ Office: _____ Worker: _____

Name of Payee _____

If applicant is not currently receiving government benefits, has an application ever been made? ☐ Yes ☐ No

If yes, to whom?_____When?_____

Results? _____

COMMUNITY MENTAL HEALTH AFFILIATION

Have you received services through a community/ public mental health agency? ☐ Yes ☐ No

Are you currently receiving services through a community/ public mental health agency? ☐ Yes ☐ No

County: _____ State: _____Agency: _____

Case Manager: _____Phone #: _____

Do you expect community mental health to pay for any of your expenses? ☐ Yes ☐ No

Explain: _____

_____

MEDICAL INSURANCE

Medicaid: Michigan Medicaid, Healthy Michigan, or Medical Assistance from state of residence

Currently active? ☐ Yes ☐ No Recipient ID #: _____

Case #: _____ Worker: _____ County: _____

Medicaid HMO: _____ Organization: _____ Member #: _____

Have you applied or received benefits in Michigan before? ☐ Yes ☐ No

Would you like assistance in applying for medical benefits in Michigan? ☐ Yes ☐ No

Medicare: Claim #: _____

Do you have Part A? ☐ Yes ☐ No Part B? ☐ Yes ☐ No Part D? ☐ Yes ☐ No

Part D Carrier:_____ #_____

Benefit / Contact Information

Private: Insurance Co: _____ Is this an HMO? ☐ Yes ☐ No

Subscriber's Name: _____ Subscriber Date of Birth: _____

Contract #: _____ Group #: _____

Does the applicant have a Primary Care Physician? ☐ Yes ☐ No (If yes, please provide contact information below.)

Physician's Name: _____ Phone: _____

Does this plan require referrals from the applicant's Primary Care Physician? ☐ Yes ☐ No

Does the insurance policy cover: Laboratory fees? ☐ Yes ☐ No Prescriptions? ☐ Yes ☐ No

Does the insurance policy have co-pays? ☐ Yes ☐ No If yes, amounts: _____

Does the applicant have dental coverage? ☐ Yes ☐ No If yes, carrier: _____ Co-pay amount: _____

Does the applicant have vision coverage? ☐ Yes ☐ No If yes, carrier: _____ Co-pay amount: _____

Does the applicant have urgent care coverage? ☐ Yes ☐ No If yes, carrier: _____ Co-pay amount: _____

Other/ Notes: _____

I am aware that, in certain instances, insurance payors (typically not Medicare or Medicaid) may provide reimbursement for some services. The insurance subscriber or legal representative may indicate below whether Rose Hill Center may contact the applicant's insurance provider to determine if any reimbursement may be available.

Note: If requested upon admission, Rose Hill has the capability of providing the financially responsible person with coded invoices for typically billable clinical services.

Does the insurance subscriber give Rose Hill consent to contact the insurance provider? ☐ Yes ☐ No

Subscriber Signature: _____

Necessary for Admission

Please attach copies to this form. We need copies of both sides of the driver's license and health insurance card.
You will need to bring the original documents with you at the time of admission.

☐ Proof of identity (driver's license, state identification card, birth certificate or other proof of identity)

If no current driver's license, has the applicant ever had one in the past? ☐ Yes ☐ No

Explain: _____

☐ Social Security card

☐ Proof of Social Security benefits (check stub, benefits letter), if applicable

☐ Medicaid card, if applicable

☐ Medicare card, if applicable

☐ Medicare Part D card, if applicable

☐ Private insurance card, vision card and/or dental card, if applicable

☐ Copy of guardianship papers, if applicable

☐ A History and Physical Form completed no more than 30 days prior to admission

CONTACT INFORMATION

Please list at least one contact. (Legal guardian contact information must be completed, if applicable.)

Contact: _____ Relationship:_____

Address:_____

City/State/Zip: _____

Home Phone: _____ Business Phone:_____ Cell Phone:_____

Email:_____

Contact: _____ Relationship:_____

Address:_____

City/State/Zip: _____

Home Phone: _____ Business Phone:_____ Cell Phone:_____

Email:_____

Legal Guardian (only if applicable):_____

Agency: _____

Address: _____

City/State/Zip: _____

Home Phone:_____ Business Phone: _____ Cell Phone: _____

Relationship to Applicant: _____ Email:_____