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

Benefit / Contact Information

POTENTIAL CLIENT INFORMATION

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Gender (Circle): Male Female Unspecified

Marital Status (Circle): Single Married Divorced Widowed Domestic Partner Separated

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (Home): _____ **(Cell):** _____ **Email:** _____

POLICY HOLDER INFORMATION

Name: _____

Date of Birth: _____ **Social Security Number:** _____

Gender (Circle): Male Female Unspecified

Martial Status (Circle): Single Married Divorced Widowed Domestic Partner Separated

Relationship to potential client (Circle): Self Spouse Child Other: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (Home): _____ **(Cell):** _____ **Email:** _____

INSURANCE INFORMATION *Please provide copies of front and back of insurance card(s).*

Name of Insurance: _____ **Plan #:** _____

Individual or group plan (Circle): Individual Group **Group #:** _____

ID #: _____

Behavioral Health Phone #: _____

Precertification Phone #: _____

Insurance Provider Phone #: _____

Benefit / Contact Information

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: _____

Primary Care Physician: _____ Phone: _____

GOVERNMENT BENEFITS

Current Social Security Disability:

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

Current Supplemental Security Income:

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

Name of Payee _____ Phone: _____

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

If yes, to whom?_____When?_____

Results? _____

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:_____ #_____

ROSE HILL

BENEFIT / CONTACT INFORMATION

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/DPOA (only if applicable):_____

Agency: _____

Address: _____

City/State/Zip: _____

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

Relationship to Applicant: _____ Email:_____

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/Durable Power of Attorney papers, if applicable
- ☐ A History and Physical Form completed no more than 30 days prior to admission