HOPEWELL
a therapeutic farm community

Introduction

Welcome to Hopewell, a place of healing and hope. We greatly appreciate your decision to pursue admission to Hopewell. At Hopewell, we understand the challenges individuals face on their journey to mental well-being. Our dedicated team provides a supportive environment tailored to your individual needs. As you contemplate coming to live in our community, imagine a place where healing is a continuous process that we embark on together. Your presence, along with that of every other member of the community will make Hopewell a place of growth and acceptance. It is our goal that your time here will be marked by self-discovery, healing, and the support of a community that believes in your potential.

Feel free to contact our team with any questions or concerns. We are here to ensure that the process of your pathway into our community is as simple and easy as it can be. Start your application process by calling us at 440-426-2009. Admissions staff are available Monday through Friday from 8:00 a.m. to 5:00 p.m. EST and will be happy to speak with you about our services, admissions criteria, and the costs of service. Visit our website at www.hopewellcommunity.org to learn more about our treatment program, our vibrant residential community, and our holistic services.

Admissions Process

Materials
Our admissions process includes compiling a comprehensive treatment history for each applicant to evaluate our community's ability to provide appropriate, quality care for each potential resident.

The material that follows is also available to download and print directly from our website at http://www.hopewellcommunity.org/admissions/apply.

The application paperwork packet includes:

Psychiatric Referral form
Must be completed by applicant's prescribing psychiatrist, or any independently licensed mental health professional

Health and Physical form
Must be completed by a medical professional

Family and Mental Health History form
Must be completed by applicant's family or primary caregiver

Strengths, Needs, Abilities, and Preferences form
Must be completed by the applicant

Authorization for Release of Confidential Information form
We ask that you sign releases that permit Hopewell to request past medical documentation from any inpatient or outpatient providers from whom you have received recent services. Medical records are reviewed by our team to assure we have appropriate services and can provide quality continuing care. (Make copies as needed)

Health Insurance Information form
The insurance form can be completed by the applicant or the applicant's family.

Next Steps
After receiving the required clinical documentation, our admissions team will assess the applicant's specific treatment needs and determine if Hopewell provides the best opportunity for successful healing. If recommended by the admissions team, an intake assessment (in person, or virtually) will be conducted by a Hopewell clinician.

Following this assessment, the team will either recommend admission or provide referrals.

Financial Arrangements
Your admissions point of contact will help you understand the costs of treatment, availability of financial assistance, and determine an appropriate means of funding care at Hopewell. Contact us for an application for financial assistance.

Medications
All residents MUST arrive with a 30-day supply of medications (preferred) or a prescription for a 30-day supply

HOPEWELL
a therapeutic farm community

Psychiatric Referral Form

This form must be completed in its entirety by a potential resident's psychiatrist, or any independently licensed mental health professional. If the individual is on medications, the prescribing professional must sign off on the current medication regimen. This form must be completed prior to our admissions decision and be updated if there are any changes prior to admission.

Name of potential resident: _____ Length of time under your care: _____

D.O.B.: ____/____/____ SSN: _____/____/_____

Prescriber's Printed Name: _____ Email _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Guardian: YES ☐ NO ☐ If yes, list name and attach a copy of guardianship papers: _____

Diagnosis: Hopewell is a therapeutic farm community specializing in mental health treatment. Our admission criteria are structured to meet a Residential Mental Health Treatment (RTC) level of care.

Please complete the DSM-5-TR Code and current diagnoses for the referred potential resident:

Code	Diagnosis

If available, please include current GAF Score: _____

Past Diagnoses include:

Code	Diagnosis

Length of stay recommended: ____3-6 months ____ 6-12 months ____ long term treatment

Current Psychiatric Prescribed Medications*:*

Please write-in below or attach a current medication record

- Provide a recent copy of drug levels for applicable medications (i.e., Lithium, Depakote, Tegretrol, Lamictal, Clozapine) and a copy of all recent lab work and drug screens. If client has a known history of substance abuse, a drug screen that has been taken within 30 days of admission is required.
- **All residents MUST arrive with a 30-day supply of medications (preferred) or a prescription for a 30-day supply**

Medication	Dose	Frequency	Rationale

Frequency of monitoring if potential resident is prescribed Clozapine: Weekly ☐ Biweekly ☐ Monthly ☐

Prn Medication	Dose	Frequency	Rationale

Name:_____ Date of Birth: _____

Current Mental Status:

YES NO Suicidal History

Ideation Dates: _____, _____, _____, _____ method_____

Plan Dates: _____, _____, _____, _____ method_____

Attempt Dates: _____, _____, _____, _____ method_____

YES NO Aggression History

☐ Verbal Who _____when_____

☐ Physical Who _____when_____

☐ Assault History Dates: _____, _____, _____, method_____

YES NO Sexual Abuse Victim / Perpetrator

Details: _____

YES NO Physical Abuse Victim / Perpetrator

Details: _____

YES NO Substance Abuse

☐ Cigarettes ☐ Caffeine ☐ Medication ☐ Alcohol ☐ Marijuana/THC

☐ Illegal (list)_____ ☐ Other_____

YES NO Recent trauma - Details: _____

YES NO Delusions

☐ Grandiose ☐ Somatic ☐ Religious ☐ Other _____

Please provide details of delusions

_____

_____

YES NO Hallucinations

☐ Auditory ☐ Visual ☐ Other _____

Please provide details of hallucinations

_____

_____

YES NO Self Harm - Details: _____

YES NO Appropriate Affect

☐ Animated ☐ Blunted ☐ Flat ☐ Inappropriate ☐ Labile ☐ Constricted ☐ Other _____

YES NO (Keeping in mind that Hopewell is an open unlocked community) Potential resident has judgment/insight relating to safety of self and others; to include children and animals. Please describe if no

_____

_____

_____

Psycho-Social History

YES NO Arrest Record

Dates: _____ reason_____

Current Status _____ Probation/Parole_____

Dates: _____ reason_____

Current Status _____ Probation/Parole_____

YES NO Homeless - Details: _____ YES

NO Family Support - Details: _____ YES

NO Independent Living Skills

☐ Regular staff support for daily prompting ☐ 1:1 staff support

Please describe if you answered no to Independent Living Skills_____

_____

What goals do you have for this individual while at Hopewell. Please list any additional information regarding this individual:

_____

_____

_____

_____

_____

Signatures

Prescriber

Printed Name _____ Date: _____

Signature _____ Credentials: _____

Other Licensed individual completing this form:

Printed Name _____ Date: _____

Signature _____ Credentials: _____

HOPEWELL
a therapeutic farm community

Health and Physical Form

Hopewell is a residential farm community for adults with chronic mental illness. This form is to be completed as an initial part of the admission assessment process and annually thereafter. Candidates need to demonstrate a level of health that allows for physical work on a farm and ability to safely navigate between buildings over uneven ground.

The History and Physical is to be completed by the potential resident's primary care provider or hospital generalist within 1 year of the date of admission.

Potential Resident Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____ Preferred Phone # _____

Medical History

Family History: Please identify biologically related family members who have had any of the following conditions:

Disease Type	**Family Members Diagnosed**	**Deceased? Yes or No**
Cancer (specify type)		
Bleeding Disorder		
Diabetes		
Genetic Disorder		
Cardiovascular Diseases		
Pulmonary Diseases		

Allergies		
Allergies:	List Allergies	List Reactions
Medication Allergies		
Food/Environmental Allergies		

Medications and Supplements:

Please list ALL medications including routine, as needed meds, nutritional supplements, herbs, vitamins and over the counter meds OR check here ☐ if medication list/MAR is attached.

Standing Medications:

Name	Dose	Time	Reason	Prescriber

Current Medical Diagnoses/Significant Health Conditions/Significant Surgeries:

_____

_____

_____

Name:_____ Date of Birth: _____

Review of Medical Systems

System Name	Normal Findings?		Comments/Description
Integumentary	☐ Yes	☐ No	
Neurologic	☐ Yes	☐ No	
Respiratory/Nose/Mouth/Throat/Lungs	☐ Yes	☐ No	
Endocrine	☐ Yes	☐ No	
Cardiovascular	☐ Yes	☐ No	
Gastrointestinal	☐ Yes	☐ No	
Special Diet	☐ Yes	☐ No	
Genitourinary	☐ Yes	☐ No	
Hematologic	☐ Yes	☐ No	
Musculoskeletal	☐ Yes	☐ No	
Reproductive	☐ Yes	☐ No	
For Women- Last mammogram?	Date:		
For Women-Last menstrual period?	Date:		
Lymphatic	☐ Yes	☐ No	
Eyes/Ears/Head/Face/Neck	☐ Yes	☐ No	
Vision and Hearing	☐ Yes	☐ No	

Height_____ Weight _____Blood Pressure _____Pulse _____Respirations _____Temp _____
Is further evaluation recommended by a specialist in any of these areas ☐ Yes ☐ No

Please explain: _____

Last dental appointment: _____ Dentist: _____

Last vision exam: _____ Doctor: _____

Is potential resident at risk for TB? Yes ☐ No ☐
If YES, please complete a 2 Step TB Test, TB blood test or Chest X-ray

2 Step TB Test Dates: Step 1: _____ Step 2: _____ Results: Step1:_____ Step 2: _____

Blood test/Chest X-ray date: _____ Results:_____(attach copy of lab report)

Is potential resident up to date on age- appropriate vaccines? ☐ Yes ☐ No

Date of last tetanus: _____

Date of last Covid vaccine: _____

Is this potential resident free of any communicable disease? ☐ Yes ☐ No If no, please explain

---

****Please provide copies of recent (within past year) lab work including TFT, liver and renal function tests, CBC, lipid profile, drug level monitoring, & drug screens****

Healthcare Provider Printed Name (PA, MD, DO or NP): _____ Title: _____

Office Address: _____ Phone # _____

City: _____ State: _____ Zip Code: _____

Healthcare Provider Signature: _____ Date: _____

Name:_____ Date of Birth: _____

HOPEWELL
a therapeutic farm community

Family and Mental Health History Form

This form must be completed by applicant's family or primary caregiver.

Name of the potential resident **(PR)** being referred to Hopewell: _____

Age: _____ DOB: ____/____/_____ SS#: _____/____/_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

County of residence _____ Phone #: _____

Current living situation: _____

Person providing information: Name: _____

Names and relationships of significant family and/or other for emergency contact purposes:

Name: _____ Relationship: _____ Cell #_____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Relationship: _____ Cell #_____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

History of behaviors that illustrate the family's concerns or reasons for the referral:

_____

_____

_____

_____

When did the family first begin to notice behaviors, which may be related to mental illness?

_____

Were there any significant and/or traumatic events in the lives of your family members? (Please describe)

_____

_____

_____

Are there any legal issues regarding the PR? ☐ No ☐ Yes (If yes please describe)

_____

_____

Does the PR have any medical problems? ☐ No ☐ Yes (If yes please describe) _____

_____

Has the PR ever suffered a head injury? ☐ No ☐ Yes (If yes please describe)

_____

Is there history of mental illness and/or alcohol & drug use in the family? ☐ No ☐ Yes

Relationship to PR: _____ Diagnosis: _____

Relationship to PR: _____ Diagnosis: _____

Is there any history of drug or alcohol abuse with the PR? ☐ No ☐ Yes

Date of last use: _____ Substances Abused: _____

Has the PR ever been hospitalized? ☐ No ☐ Yes (If yes please provide name(s) of hospital(s) in the table below
Please provide a list of all treatment facilities and or providers. Include the last two years of hospitalizations, inpatient programs, partial hospitalization programs, intensive outpatient programs, and outpatient providers. Use additional pages if necessary.

Provider	Type of Provider	Dates of Treatment

Is a mental health agency currently providing case management for the PR? ☐ No ☐ Yes (If yes, please fill out next line)

Name of agency: _____ Case Manager: _____ Ph # _____

Please describe the PR's strengths _____

_____

_____

Please describe any limitations the PR may have with regard to daily living skills, i.e.: self-care, bathing, dressing, cleanliness, vocational skills, social skills: _____

_____

_____

Please describe any concerns or issues the PR may have regarding sexual history:_____

_____

_____

Identify if there is a history of any of the following: Please explain any [X] areas

☐ Physical Abuse: _____

☐ Mental Abuse: _____

☐ Sexual Abuse: _____

☐ Emotional Abuse: _____

☐ Domestic Violence: _____

☐ Community Violence: _____

☐ Physical Neglect: _____

☐ Elder Abuse: _____

☐ Cruelty to Animals: _____

Please identify any additional information that would be important for us to understand about the potential resident.

_____

_____

Did PR ever serve in the military? ☐ No ☐ Yes

Does PR receive VA benefits? ☐ No ☐ Yes Amount per month $ _____

Is the PR currently receiving Social Security benefits? ☐ No ☐ Yes Amount per month $ _____

Is there a payee? ☐ No ☐ Yes

Please provide name/address/phone # _____

_____

To what extent does the family or PR consider spirituality or religion important to their lives?

_____

Are there any significant cultural or ethnic matters we should know about? _____

_____

Please provide a history of the educational experiences for the PR: _____

_____

_____

Please provide a history of the vocational or work experiences for the PR: _____

_____

_____

_____

Identify any problems in the following areas: Please explain any [X] areas

☐ Nutrition/Eating patterns, changes, disorders: _____

☐ Pain Management: _____

☐ Depressed Mood/sad: _____

☐ Anxiety: _____

☐ Traumatic Stress: _____

☐ Anger Aggression: _____

☐ Oppositional Behaviors: _____

☐ Inattention/Withdrawal: _____

☐ Impulsivity: _____

☐ Disturbed Reality Content (psychosis): _____

☐ Bizarre Thoughts: _____

☐ Mood Swings/Hyperactivity: _____

☐ Sleep Problems: _____

☐ Social Stressors: _____

☐ History of harming self or others: _____

_____

_____

HOPEWELL
a therapeutic farm community

Hopewell is not a locked or gated facility. Hopewell does not provide 24/7 eyes-on supervision. This can result in challenges with monitoring risky behaviors. Therefore, we ask that you answer the following questions candidly to assist us with assessing the safety the needs of the potential resident.

What is your assessment about whether the potential resident is currently at risk of suicide or inclined in any way to harm themselves or others? Please provide specifics about the history of any of these behaviors.

_____

_____

_____

_____

What is your assessment about the potential resident being responsible for their own behavior and safety in an open rural and urban environment?

_____

_____

_____

What is your assessment about the potential resident being able to care for their own personal hygiene?

_____

_____

What is your assessment of the potential resident being both able and motivated to participate in the Hopewell program?

_____

_____

What is your assessment of the potential resident being able to refrain from using illegal substances, marijuana/THC, and alcohol, in addition to adhering to smoking in designated areas only?

_____

_____

_____

What is your assessment of the potential resident being able to function relatively independently as well as safely without close supervision? _____

_____

By signing below, I am indicating that I have provided the most accurate and truthful information regarding these critical issues related to the safety and welfare of the potential applicant and the Hopewell community.

Does the PR have a legal guardian? ☐ No ☐ Yes If yes, guardian of: ☐ Person ☐ Estate ☐ Both

Please provide name/ address/ phone # and attach proper documentation of guardianship.

Guardian Name _____ Phone # _____

Guardian Address: _____

City: _____ State: _____ Zip Code: _____

Printed Name _____ Contact Phone # _____

Signature _____ Relationship to Applicant _____

Name:_____ Date of Birth: _____

HOPEWELL
a therapeutic farm community

Strengths, Needs, Abilities, and Preferences Form

This form must be completed by the applicant. Potential resident may request assistance from others to complete this form if necessary.

Person Assisting (if requested) _____**Date**_____

Strengths/Resources	**Needs**
What are some things that help you? Check all that apply and list others you think will help. ☐ 1. Support from family (parents, children, others) ☐ 2. Support from spouse or significant other ☐ 3. Connection to self-help group (AA, NAMI, etc.) ☐ 4. A positive and supportive sponsor ☐ 5. Connection to a church group or minister ☐ 6. Access to a spiritual practice group ☐ 7. Counselor of case manager who helped you get into treatment ☐ 8. Someone who helped you get into Hopewell ☐ 9. Financial assistance or benefits coming to me ☐ 10. Permanent residence/housing option ☐ 11. Work/ vocational options/connections at discharge ☐ 12. Work/ vocational experience doing_____ ☐ 13. Connections to volunteering I have done ☐ 14. Connection to a community _____ ☐ 15. Connections to a mental health facility and/or psychiatric care; provisions for obtaining medications ☐ 16. Supportive friends ☐ 17. Community involvement_____ ☐ 18. A guardian who is helpful ☐ 19. Recreation/leisure connections ☐ 20. Driver's license ☐ 21. Others: _____ _____ _____ _____ _____ _____	**What do you want to learn while at Hopewell? Check all that apply and list other things you can think of that are not shown.** ☐ 1. Education about mental disorders ☐ 2. Education about substance abuse ☐ 3. An explanation of my diagnosis ☐ 4. Improvement in my communication skills ☐ 5. Improvement in my interpersonal skills ☐ 6. Contact with supportive others ☐ 7. Emotion-management skills ☐ 8. Anger-management skills ☐ 9. A personal safety plan ☐ 10. Medication education ☐ 11. Getting and keeping a job ☐ 12. Education about improving my health ☐ 13. Relapse prevention or recovery plan ☐ 14. Coping with symptoms e.g., voices, confusion Specific symptoms_____ ☐ 15. Relapse prevention skills ☐ 16. Art & creative expression class ☐ 17. Money management skills e.g., checking ☐ 18. Independent living skills e.g. cooking, ☐ 19. Assistance with housing ☐ 20. Empowerment/advocacy training ☐ 21. Benefit analysis for SSI/SSDI and work ☐ 22. Understanding of how Hopewell works for me ☐ 23. Exercise opportunities & guidance ☐ 24. ADL assistance e.g., grooming hygiene ☐ 25. Managing sleep schedule ☐ 26. Help dealing with groups and many people ☐ 27. Support to manage limitations in _____ ☐ 28. Others: _____ _____ _____ _____ _____ _____ _____

Name:_____ Date of Birth: _____

HOPEWELL
a therapeutic farm community

Abilities **Preferences/Expectations**

What are some of your personal qualities, skills or talents that will help you in recovery? Check all that apply and list others you think will help.

- ☐ 1. I am very motivated for treatment
- ☐ 2. I am able to make an appropriate transition to living in a recovering community
- ☐ 3. I have good interpersonal/communication skills
- ☐ 4. I have good emotion-management skills
- ☐ 5. In the past I have demonstrated openness and honesty **with** regard to my recovery
- ☐ 6. I have been able to let go of the denial that I once had about my mental disorder
- ☐ 7. I have been able to let go of the denial that I once had about my substance abuse
- ☐ 8. I have some insight into my substance abuse and mental disorder
- ☐ 9. I have good self-esteem
- ☐ 10. I have some positive plans and goals for my future
- ☐ 11. I am willing to do what it takes to be in recovery
- ☐ 12. I have good work skills doing_____
- ☐ 13. I'm aware of how work effects benefits
- ☐ 14. I'm aware of supports/resources in my community
- ☐ 15. I have a good relationship with a higher power
- ☐ 16. In spite of past hardships, there are still areas of my life in which I take pleasure
- ☐ 17 I am a helpful caring person, capable of offering support to others in recovery
- ☐ 18. Able to function in groups
- ☐ 19. Good grooming hygiene & self-care
- ☐ 20. I'm generally physically fit
- ☐ 21. Good spiritual practice e.g., prayer, yoga
- ☐ 22. I can teach or offer my experience in_____
- ☐ 23. I have already overcome obstacles in my life.
- ☐ 24. Special talents_____
- ☐ 25. I am knowledgeable in_____
- ☐ 26. Others: _____

_____
_____
_____
_____
_____
_____

What do you hope to get out of Hopewell? Check all that apply and list other things you can think of that are not shown.

- ☐ 1. I will learn the skills to stay mentally stable
- ☐ 2. I will learn the skills to stay clean and sober
- ☐ 3. I will have a better understanding of my diagnosis
- ☐ 4. I will be able to communicate more effectively
- ☐ 5. My interpersonal skills/relationships will improve
- ☐ 6. I will develop a system of support in recovery
- ☐ 7. I will be able to better manage my emotions
- ☐ 8. I will be able to better manage my anger
- ☐ 9. My health will improve _ physically__ mentally
- ☐ 10. I will have a better understanding of relapse prevention
- ☐ 11. I will have an illness management plan
- ☐ 12. I will learn how to reunite with my family
- ☐ 13. I will learn to get a job
- ☐ 14. I will learn ways to live well & be happy
- ☐ 15. Personal safety plan preferences
  - PRN meds ____
  - Physical restraint ____
  - Open quiet room ____
- ☐ 16 I will learn self-advocacy & empowerment
- ☐ 17 I will learn how to engage in activities I enjoy
- ☐ 18 I prefer to work in
  - Large Groups___
  - Small Groups___
  - Individually___
- ☐ 19. Exercise in class, equipment, inside or outside
- ☐ 20. Spiritual/religious preference_____
- ☐ 21. Less help will be needed from case mangers & staff
- ☐ 22 I will stay out of the hospital
- ☐ 23 I will take my medication as prescribed
- ☐ 24 I will use coping skills instead of self-harming
- ☐ 25 Other: _____

_____
_____
_____
_____
_____
_____
_____

Name:_____ Date of Birth: _____

HOPEWELL
a therapeutic farm community

Authorization For Release of Confidential Information

Potential/Resident Printed Name _____ Date of Birth _____
Last First

This release authorizes: Hopewell staff to: ☑ receive from, ☑ disclose to:

_____
(Name of Organization/Person & Relationship

Phone # _____ Fax # _____

Please provide information in the format checked: ☐ Verbal ☐ Written ☑ Verbal and/or written

Description of Information to be released:

☑ Diagnostic Assessment & Updates	☑ Treatment Plans	☑ Information Shared During Staffing
☑ Psychiatric Examinations	☑ Orders	☑ Progress Notes
☑ Psychological Evaluations	☑ Consultations	☑ Lab Results
☑ Nursing Assessment	☑ Quarterly Report	☑ Discharge Summaries
☑ Health History & Physical	☑ Drug Screens/Treatment	☐ Other (specify)_____

Purpose of disclosure is to: ☑ Assess for Possible Admission ☑ Continuity of Care ☐ Updates on Progress ☐ Other

I understand that I, and/or, my guardian, if appropriate, may shorten or lengthen the authorization period or may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously shortened, lengthened or revoked, this authorization is valid for the duration of treatment and residence at Hopewell.

I understand that the information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, I understand that Hopewell cannot control the recipient's use of the information.

I understand that my treatment, payment for my services, my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV)/acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3). I understand that the information disclosed is protected by law and may not be redisclosed without my written consent or as otherwise authorized by law; however, I understand that Hopewell cannot control the recipient's use of the information. Records obtained from other sources and made available to Hopewell may not be redisclosed to other parties.

_____
Signature of Individual **Date**

_____
Signature of Guardian **Relationship to Potential/Resident** **Date**

_____
Signature of Hopewell staff facilitating disclosure of information **Date**

TO BE SIGNED ONLY IF AUTHORIZATION IS REVOKED

This authorization can be revoked at any time by providing written notice to Hopewell. I understand that any information released prior to revocation cannot be retrieved and that Hopewell will not be held responsible for such. I hereby release Hopewell from all legal responsibilities or liability that may arise from this act.

Signature Of Individual/Guardian: _____Date: _____

Witness: _____ Time: _____ Date: _____

Name:_____ Date of Birth: _____

HOPEWELL
a therapeutic farm community

Health Insurance Information Form

Please fill out this form in its entirety. Attach a copy of both front and back of each insurance card and valid driver's license or other identification card with this form.

Primary Health Insurance

Resident's Name:_____ DOB: _____

Subscriber's Name:_____ DOB:_____ SS#: _____

Name of Insurance Company: _____

(Medical) Subscriber's ID # :_____ Group #:_____

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Employer:_____

A quote of benefits and /or authorization does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. Once approved, your insurance company may choose to no longer cover the Resident's care because they do not deem a residential level of care medically necessary. At that point you will be given a choice for the Resident to be referred to an in-network outpatient provider, or to stay at Hopewell. Should the Resident decide to stay at Hopewell, you will be responsible for all fees. The existence of available insurance or governmental agency monies, does not replace or relieve the Responsible Party of his or her joint and several obligations under the Admission Agreement for the payment of fees.

Vision Insurance

Subscriber's Name:_____ DOB:_____ SS#: _____

Name of Insurance Company:_____

(Vision) Subscriber's ID # :_____Group #:_____

Dental Insurance

Subscriber's Name:_____ DOB:_____ SS#: _____

Name of Insurance Company:_____

(Dental) Subscriber's ID # :_____Group #:_____

Pharmacy Insurance

RxBIN: _____

RxPCN:_____

RxGRP:_____ (If there is a secondary insurance please send copies as well.)

Please indicate if there is a specific location/pharmacy your insurance company requires you to have prescriptions filled. _____

Name:_____ Date of Birth: _____