Pre-Admission Application
For
Envive Healthcare of Beech Grove
501 N. 17th Avenue
Beech Grove, Indiana 46107
(317) 786-2261

Accommodations requested:

Apartment: ☐Large ☐ Medium ☐ Small
Residential: ☐1-Bedroom Large ☐ 1- Bedroom Small
☐Studio Large ☐ Studio Small
Healthcare: ☐Semi-private ☐Private

It is the policy of Envive Healthcare to admit and provide services to all residents without regard to race, color, national origin, handicap, or age. Envive Healthcare is an equal-opportunity employer.

Please tell us about yourself. Answer all questions completely and accurately. Your responses will be held in confidence.

Name_____ Maiden Name_____

Current Address_____

City_____ ST_____ Zip_____ Email _____

Home Telephone ( )_____ Mobile Phone ( )_____

Date of Birth Month_____ Day_____ Year_____

Place of Birth City_____ State_____

Religious Denomination_____ Parish_____ (Optional)

Present Pastor_____

Your last employer?_____

City/State_____ Date of retirement_____

Are you? Married_____ Single_____ Divorced_____ Widowed_____

Date of Marriage_____ Church_____

Name of Spouse_____ If living, where?_____

If deceased, give date of death_____

Last school/university attended?_____

Military Branch served?_____ Dates_____ Rank_____

Hobbies and Interests?_____

Envive Healthcare of Beech Grove has adopted a **no smoking policy** as a condition of admission, I understand that I will not be allowed to smoke within the building or anywhere on the campus.

Please tell us about your family:
Number of living children_____ Sons_____ Daughters_____

Name_____ Name_____
Address_____ Address_____
City/ST/Zip_____ City/ST/Zip_____
Phone_____ Phone_____
Occupation_____ Occupation_____
Phone_____ Phone_____
e-mail_____ e-mail_____

Name_____ Name_____
Address_____ Address_____
City/ST/Zip_____ City/ST/Zip_____
Phone_____ Phone_____
Occupation_____ Occupation_____
Phone_____ Phone_____
e-mail _____ e-mail _____

Name_____ Name_____
Address_____ Address_____
City/ST/Zip_____ City/ST/Zip_____
Phone_____ Phone_____
Occupation_____ Occupation_____
Phone_____ Phone_____
e-mail _____ e-mail _____

Have you chosen a **health care representative**? YES_____ NO____

If yes, please list below:

Name_____ Relationship_____
Address_____ e-mail _____
City/ST/Zip_____ Phone_____

Name_____ Relationship_____
Address_____ e-mail _____
City/ST/Zip_____ Phone_____

In Case of Emergency:
Please list names in sequence to call with Health Care Representative being first.

First: (Our primary emergency contact)
Name_____ Relationship_____
Address_____ Phone_____
City/ST/Zip_____ Phone_____
e-mail _____

Second
Name_____ Relationship_____
Address_____ Phone_____
City/ST/Zip_____ Phone_____
e-mail _____

Third
Name_____ Relationship_____
Address_____ Phone_____
City/ST/Zip_____ Phone_____
e-mail _____

Attorney_____ Address_____
Office phone_____ Have you made a will? Yes_____ No_____
Do you have a Living Will? Yes_____ No_____
If yes, where are they located?_____
Who is the executor of your estate?_____

Hospital Preference

Should you need hospitalization, which hospital would you prefer? (In case of true emergency, you would be transported to the closest hospital.) _____

Burial Arrangements

What funeral director shall we contact?_____
Address_____
Phone_____

Do you wish to have the funeral service at St. Paul Hermitage? Yes____ No____
If not, where would you like your services to be held?_____
Notes/Instructions someone should know_____

Have you prepaid your arrangements? Yes____ No_____
Cemetery_____ Holder of Deed_____
Section_____ Lot_____ City_____ State_____

Financial Disclosure

Envive Healthcare of Beech Grove requires your financial disclosure to determine your qualification for residency. In completing this application, the applicant or responsible party affirm that the information submitted is true and correct to the best of their knowledge. Falsifying any information may constitute grounds to terminate a resident agreement.

Will you take care of your own finances? Yes____ No____
If not, whom have you chosen to assist you with your finances?
Name_____
Address_____
City/ST/Zip_____
Phone_____ e-mail_____
Does this person hold your Power of Attorney? Yes____ No____

Financial Assets

Please list all assets including description, location and value. Include cash, checking, savings, certificates of deposit, stocks, bonds, annuities, trusts or other assets.

Description of Asset	Location or Name	Approximate value
Cash Accounts:		
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____
Investments:		
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____

Trusts Established: _____ _____

Real Estate You Own: _____ _____
_____ _____

If someone else holds the title to any assets with you, please explain:_____
_____

Income – Monthly

Social Security $_____
Pension or Retirement $_____
Dividends/Annuities $_____
Income from Property $_____
Income from Trusts $_____

Financial Liabilities

Credit Cards	Name	Balance Due/Payment
	_____	_____/_____
	_____	_____/_____
	_____	_____/_____
Mortgage	_____	_____/_____
	_____	_____/_____
Mortgage Guarantee(s)	_____	_____/_____
	_____	_____/_____
Auto Loans	_____	_____/_____
	_____	_____/_____
Pledges to Churches/Charities	_____	_____/_____

Medical/Medications $_____per month

Health Insurance

Social Security #_____ Medicare #_____

Do you have Medicare Part A? Yes_____ No_____ Medicare Part B? Yes____ No____
Does your supplemental insurance include prescription drug coverage?
Yes____ No_____
Medicare Supplemental Insurance Company_____
Monthly Premium $_____ Paid through pension? Yes____ No____

Do you have Medicare Part D (prescription drug coverage)? Yes___ No___
Medicare Part D insurance company_____
Monthly premium $_____ Paid through Social Security? Yes___ No___

Do you have additional health insurance coverage? Yes___ No ___
Name of additional company_____
Type of coverage_____ Monthly premium $_____

Do you have an assigned Medicaid #? Yes____ No____
Medicaid #_____ Date of eligibility_____

Long Term Care Insurance
Do you own long term care insurance? Yes____ No____
Company Name_____
Your account number_____
Address_____
City/ST/Zip_____
Phone_____
Annual premium $_____
Per-diem benefit $_____ Lifetime maximum benefit $_____
Is there a waiver of premium if policy is in use? Yes_____ No_____Yes___No_____

When are you looking to move into Envive Healthcare of Beech Grove?

As soon as possible ___
1-3 months ___
4-6 months ___
7-12 months ___
One year or more ___ Approximate date_____

Certification and Signature

I submit this pre-admission application for Envive Healthcare of Beech Grove of my own free will. I hereby declare that all statements made herein are true according to my best knowledge and belief. I understand that information contained herein will be reviewed by the admission committee of Envive Healthcare of Beech Grove to assist in their decision to enter into a service and care agreement with me. I agree that I and my responsible party (if applicable) will apply my assets and income as necessary for payment of my stay at Envive Healthcare of Beech Grove until such assets are exhausted or until I leave Envive Healthcare of Beech Grove. I agree that I have not and will not in the future, engage in any act that renders me ineligible for Medicaid or any similar form of public assistance.

Signature_____ Date_____

Printed name_____ Date_____

Is the signer (please check all that apply):

_____Applicant
_____Spouse
_____Responsible Person
_____Child
_____Guardian*
_____Attorney in Fact (POA)*
_____Health Care Representative*

*Please attach legal documents.

If you have any further questions, please feel free to contact our Executive Director at (317) 786-2261.

Thank you for your interest in making Envive Healthcare of Beech Grove your home. We look forward to having you join our community.