Turning Leaf
Residential Rehabilitation
621 E. Jolly Road
Lansing, MI 48910
517-393-5203 Phone
517-393-8968 Fax

FINANCIAL FORM

As parent(s) or guardian of _____, I (we) will take full responsibility
(applicant)

to see that the Turning Leaf Residential Rehabilitation fee is paid.

(please check one)

_ Privately

_ By CMH funding from _____ County
(Michigan residents only)

Contact person: _____ Phone _____

Agency: _____

Does this County have a contract with Turning Leaf Residential Rehabilitation? _ Yes _ No

At the request of the Executive Director of Turning Leaf Residential Rehabilitation or designee, I (we) agree to come for the resident immediately if he or she must leave Turning Leaf Residential Rehabilitation for medical, psychiatric, legal, or behavioral reasons.

I (we) also agree to be financially responsible for all other expenses incurred by the resident while at Turning Leaf Residential Rehabilitation, including any medical expenses not covered by insurance.

Signed Parent/Guardian:_____ Date: _____

Name _____

Address: _____

City/State/ZIP _____

Home phone:_____ Business phone: _____

Name _____ S.S. #_____ D.O.B_____

The following must be completed for admission to Turning Leaf Residential Rehabilitation.

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?_____

Results?_____

Would you like assistance in applying for or managing benefits? _ Yes _ No

If so, attach proof of all assets/bank accounts in applicant's name. You may be expected to provide additional assistance as requested. Any other relevant information _____

_____

Medical Insurance

Medicaid: Currently active _ Yes _ No Recipient ID #_____

Case #_____ Worker _____ County_____

Medicaid HMO: Organization_____ Member #_____

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

If yes, attach proof of all Social Security benefits, assets/bank accounts in the applicant's name.

Medicare: Claim #: _____ Do you have Part A? _ Yes _ No Part B? _ Yes _ No

Private: Insurance Co. _____ Contract#_____

Group#_____ Subscriber_____

Is this an HMO? _ Yes _ No Do you have a Primary Care Physician? _ Yes _ No

If yes, please provide doctor's name and telephone # _____

Does this plan require referrals from your Primary Care Physician? _ Yes _ No

Does your insurance cover: Psychiatric visits? _ Yes _ No / Laboratory fees? _ Yes _ No / Prescriptions? _ Yes _ No

Do you have co-pays? _Yes _ No If yes, amounts _____

Other/Notes: _____

Name: _____ **S.S. #** _____ **D.O.B.** _____

Community Mental Health Affiliation

Have you received services through a community mental health agency? _ Yes _ No Currently _ or In the past _

County _____ **Agency** _____

Case Manager _____ **Phone** _____

Do you expect the county to pay for any of your expenses? _ Yes _ No

Explain _____

_____

Necessary for Admission

Attach *copies* of the following to this form. Bring originals at time of admission.

- ☐ **History and Physical Examination (within the last 30 days.) THIS IS MANDATORY.**
- ☐ **Driver's license, if applicable** ***(If no current driver's license, was there one in the past? _ Yes _ No)***
  Explain _____
  OR ☐ State Identification Card, Birth Certificate or other proof of identity
- ☐ **Social Security card**
- ☐ **Proof of Social Security benefits (check stub, benefits letter), if applicable**
- ☐ **Medicaid card, if applicable**
- ☐ **Medicare card, if applicable**
- ☐ **Private Insurance card, if applicable**

In Case of Emergency

Other persons to contact in case of emergency, if parent/guardian cannot be reached:

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City/State/ZIP _____ **City/State/ZIP** _____

Home Phone _____ **Home Phone** _____

Business Phone _____ **Business Phone** _____

Relationship to Applicant _____ **Relationship to Applicant** _____