NORA'S HOME
for transplant patients and their families

REFERRAL FORM

8300 El Rio | Houston, TX 77054

Fax to 832.804.9954 or email to **marilda@norashome.org** or **info@norashome.org**
Questions? Please call 832.831.3720

How did you hear about Nora's Home?

- ◯ Referral from transplant center
- ◯ Family/Friend
- ◯ Website
- ◯ Internet Search
- ◯ Word of mouth
- ◯ Other: _____

Today's date:

PATIENT INFORMATION

Patient's last name:	First Name:	Middle Name:	☐ Mr. ☐ Mrs. ☐ Ms.
Nickname:	Email:	Birth date: / /	Age: / Sex: ☐ M ☐ F
Address:			
City:	State:	Zip Code:	

Please list family members or caregiver who will be staying w/patient. (Max 4 people per room)
(Guests must be 10 yrs.or older)

_____ _____

_____ _____

Driver's License Number(s):	Phone Number:
Requested Check in date:	Anticipated Check out date:

(In the case of a waiting list, max length of stay – 30 days)

ADDITIONAL INFORMATION

Patients Transplant: ☐ Kidney ☐ Liver ☐ Heart ☐ Lung ☐ Pancreas ☐ LVAD ☐ Organ donor

Check Reason for Medical visit:

- ☐ Transplant Evaluation
- ☐ Pre-Transplant Appointment
- ☐ Post-Transplant Appointment
- ☐ Transplant Surgery
- ☐ Emergency Hospitalization
- ☐ Other, please explain _____

Hospital Name:	Doctor:	
Social Worker Name:	Phone:	Email:

Does your insurance allow for medical lodging reimbursement? ☐ Y ☐ N Does the patient have Medicaid? ☐ Y ☐ N
If so, please list your insurance company or Medicaid Program Organization _____
What is the member number for the insurance or Medicaid? _____
If not, please list your monthly household income. _____

NORA'S HOME OFFICE USE ONLY

Received by: Date/Time: Approval: Rate:

Disclosure
The above information is true to the best of my knowledge. I authorize the transplant Social Worker/Coordinator to disclose and release this information, and any other information requested, to Nora's Home. I authorize Nora's Home to investigate my background and qualifications for purposes of evaluating whether I am qualified to be a guest at Nora's Home. I understand that Nora's Home will utilize an outside firm or firms to assist it in checking such information, and I specifically authorize such an investigation by information services and outside entities of the company's choice. I also understand that I may withhold my permission and that in such a case, no investigation will be done, and my application to be a resident will not be processed further.

Guest Signature Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to **Nora's Gift Foundation, Inc. ("Nora's Home")**, as my designated authorized representative, all benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered or lodging provided by **Nora's Home**, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize **Nora's Home** to release all information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to **Nora's Home** any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from **Nora's Home** or its attorneys in order to claim such benefits.

In addition to the assignment of the benefits and/or insurance reimbursement above, I also assign and/or convey to **Nora's Home** any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of the services rendered or lodging provided by **Nora's Home** (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims relating to services rendered or lodging provided by Nora's Home.

I intend by this assignment and designation of authorized representative to convey to **Nora's Home** all of my rights to claim (or place a lien on) the benefits related to the services rendered or lodging provided by **Nora's Home**, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative **(Nora's Home)** is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing owwwr receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. **Nora's Home**, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under the Affordable Care Act (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date