ADULT DAY CARE

Application for Admission

Long Island State Veterans Home
State University of New York at Stony Brook
100 Patriots Road
Stony Brook, New York 11790-3300

Office #: (631) 444-8530
FAX #: (631) 444-8534

***The program is open to veterans, their spouses, widows or eligible dependents.**
The LISVH is moving toward a Smoke Free Enviroment, we will no longer be admitting registratants who smoke at program. Smoking is permitted by,"Residents & Adult Day Care Registrants who were admitted prior to 10/21/08."

PLEASE ATTACH COPIES OF THE FOLLOWING WITH COMPLETED APPLICATION:

a) **Honorable Discharge or other proof of veteran status**
b) **Medicaid Card**
c) **Medicare Card**
d) **Other insurance cards**

(PLEASE PRINT)

1. **NAME** Last First Middle

2. **SEX** ☐ Male ☐ Female Maiden Name

3. **PRESENT ADDRESS** **Telephone #** ( )

3 a. **CROSS STREET**

4. **How did you learn about the program?**

5. **Date of Birth** **Age** **Place of Birth**

6. **MARTIAL STATUS** ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

7. **Social Security #** **Medicare #**

8. **Medicaid #** **County of Coverage** **Overage**

9. **Other Insurance**

10. **PRIMARY LANGUAGE** ☐ English Other (specify)

11. **RACE/ETHNICITY** ☐ White ☐ White/Hispanic ☐ Black ☐ Black/Hispanic ☐ Asian/Pacific Islander ☐ Other
☐ Asian/Pac.Islander/Hispanic ☐ Am. Indian/Alaskan Native ☐ Am. Indian/Alaskan Native/Hispanic

12. **ADVANCED DIRECTIVES** ☐ Living Will ☐ Do Not Resuscitate ☐ Health Care Proxy

13. **LEGAL REPRESENTATIVES** ☐ Power of Attorney ☐ Guardian ☐ Committee ☐ Other

14. **RELIGION**

15. **RESIDENTIAL STATUS** ☐ Live Alone ☐ With Family ☐ Adult Home ☐ Other

16. **LIFETIME OCCUPATION**

17. **US CITIZEN** ☐ YES ☐ NO

18. **EDUCATION (Highest Completed):** ☐ No Schooling ☐ 8th grade/less ☐ Grades 9-11 ☐ High School ☐ Tech./Trade School
☐ Some College ☐ Bachelor's Degree ☐ Graduate Degree

19. **War in which service was rendered** **Date of entry into active duty**

20. Date of Discharge _____ Type of Discharge _____

21. Resident of which state at time of entry _____

22. Service Serial Number _____

23. Please list the name, address, and telephone numbers of three (3) persons to be contacted in case of emergency in the order they should be contacted:

1.
Name (F/L): _____ Relationship: _____

Address: _____

_____

_____

Home Telephone #: ( ) _____ Work Telephone #: ( ) _____
Cellphone #: ( ) _____ Pager #: ( ) _____

2.
Name (F/L): _____ Relationship: _____

Address: _____

_____

_____

Home Telephone #: ( ) _____ Work Telephone #: ( ) _____
Cellphone #: ( ) _____ Pager #: ( ) _____

3.
Name (F/L): _____ Relationship: _____

Address: _____

_____

_____

Home Telephone #: ( ) _____ Work Telephone #: ( ) _____
Cellphone #: ( ) _____ Pager #: ( ) _____

24. Doctor's Name: _____ Telephone #: ( ) _____

Address: _____ FAX#: ( ) _____

_____

_____

25. What days would you like to attend the program? (Please check)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

26. SIGNATURE: _____ DATE: _____
(Person Completing Application)

The LISVH does not discriminate based upon race, color, creed, age, blindness, sex, sexual preference, national origin, martial status, disability, sponsorship, or source of payment, or retention and care of registrants.
The information on this application is confidential and will be used for admission and care at the program.
This data will be maintained in your medical record at the program.
We reserve the right to verify information herewith provided.

REV. 11/2008