

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 Environment, we will no longer be admitting registrants 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.