LONG ISLAND STATE VETERANS HOME
State University of New York at Stony Brook
100 Patriots Road
Stony Brook, New York 11790-3300

APPLICATION FOR ADMISSION

(631) 444-8548 OFFICE
(631) 444-8573 FAX

PLEASE SUPPLY PROOF OF VETERAN STATUS, COPIES OF ALL INSURANCE CARDS, AND ADVANCE DIRECTIVES ALONG WITH COMPLETED APPLICATION.

LISVH DOES NOT DISCRIMINATE BASED UPON RACE, COLOR, CREED, AGE, BLINDNESS, SEX, SEXUAL PREFERENCE, NATIONAL ORIGIN, MARITAL STATUS, DISABILITY, SPONSORSHIP OR SOURCE OF PAYMENT AND RETENTION AND CARE OF RESIDENTS.

INFORMATION INTAKE: (Please print)

NAME OF APPLICANT ____
Last Name First Name Middle Initial

RACE/ ETHNICITY (Check one) ___ WHITE ___ WHITE/HISPANIC ___ AFRICAN-AMERICAN ___ AFRICAN-AMERICAN/HISPANIC
___ ASIAN/PACIFIC ISLANDER ___ ASIAN/PACIFIC ISLANDER/HISPANIC ___ AMERICAN INDIAN/ALASKAN NATIVE
___ AMERICAN INDIAN/ALASKAN NATIVE/HISPANIC ___ OTHER

Applicant's Last Address:	Medicare Number: Part A ___ Part B ___ Part D ___	Name of Medicaid Caseworker/ Phone #:
Social Security Number:	Medicaid Number:	Medicaid County:
Date of Birth: Age:	Sex: _____M _____F Religion:	Place of Birth: Marital Status:

DESIGNATED REPRESENTATIVE/LEGAL GUARDIAN AND OTHERS TO BE NOTIFIED IN CASE OF EMERGENCY

NAME	RELATIONSHIP TO APPLICANT	ADDRESS	TELEPHONE #
1)			
2)			
3)			

HEALTH INSURANCE INFORMATION ** Please call your Benefits Office for Pre-Authorization Requirements.

Primary Insurance (Other than Medicare) Pre-Authorization Required? Yes ___ No___ HMO? ___Yes______No_______	Policy Number/ Name of Insured	Telephone Number of Benefits Office
Secondary Insurance: Pre-Authorization Required? Yes___ No____	Policy Number/ Name of Insured	Telephone Number of Benefits Office
Prescription Drug Plan? Yes ___ No ___	Company	

RESIDENT INFORMATION/CUSTOMARY ROUTINE

NAME OF RESIDENT: ______________________________________

Please complete the following questions concerning the applicant in the year prior to admission to the nursing home, or the last year in community if now being admitted from another nursing home to the best of your ability:

LIFETIME OCCUPATION: _______________ **HIGHEST LEVEL OF EDUCATION:** _________________ .

PRIMARY LANGUAGE: _____________ **MENTAL HEALTH HISTORY:** ___ **YES** ___ **NO**

YES	NO	UNKNOWN	
			Stays up late at night (e.g., after 9:00 PM)
			Naps regularly during day (at least 1 hour)
			Goes out 1+ days a week
			Stays busy with hobbies, reading, or fixed daily routine
			Spends most time alone or watching TV
			Moves independently outdoors (with appliances, if used)
			Use of tobacco products at least daily
			Distinct food preferences
			Eats between meals on all or most days
			Use of alcoholic beverage(s) at least weekly
			In bed clothes much of day
			Wakens to toilet all or most nights
			Has irregular bowel movement pattern
			Prefers showers for bathing
			Prefers bathing in PM
			Daily contact with relatives/close friends
			Usually attends religious services
			Finds strength in faith
			Daily animal companion/presence
			Involved in group activities

Please list all hobbies/activities the applicant has been involved/interested in: (i.e., cards/games, arts/crafts; exercise/sports, music, reading/writing/ spiritual/religious, trips/shopping, TV/movies, gardening/plants, talking/groups, helping others, etc.:

____

____

____

Please describe applicant's ability to communicate (hearing, sight, speaking, receive information)

____

____

LONG ISLAND STATE VETERANS HOME FINANCIAL DISCLOSURE

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NAME OF APPLICANT ____ DATE _______________________________

NAME OF PERSON COMPLETING THIS FORM _________________________PHONE NUMBER (___)____________

THE FINANCIAL DISCLOSURE MUST BE COMPLETED AND SIGNED.

		APPLICANT	*APPLICANT'S SPOUSE*
INCOME:	*CLAIM/ ACCOUNT NUMBERS (IF APPLYING TO MEDICAID)*	*STATE MONTHLY AMOUNTS*	*STATE MONTHLY AMOUNTS*
SOCIAL SECURITY			
PENSIONS (i.e., RAILROAD RETIREMENT)			
SSI AMOUNT			
VETERAN BENEFITS			
OTHER (SPECIFY)			
ASSETS:			
1ST CHECKING ACCOUNT (NAME OF BANK)			
2ND CHECKING ACCOUNT (NAME OF BANK)			
1ST SAVINGS ACCOUNT (NAME OF BANK)			
2ND SAVINGS ACCOUNT (NAME OF BANK)			
OTHER ACCOUNTS (i.e., IRA, CREDIT UNION, TRUST FUND)			
STOCKS AND BONDS			
INTEREST IN ESTATES/TRUSTS			

		APPLICANT	APPLICANT'S SPOUSE
INCOME:	***CLAIM/ ACCOUNT NUMBERS (IF APPLYING FOR MEDICAID):***	***STATE MONTHLY AMOUNTS***	***STATE MONTHLY AMOUNTS***
ANNUITIES, MORTGAGES, ETC.			
CASH ON HAND			
SAFE DEPOSIT BOX			
OWN HOME (CURRENT VALUE)			
OTHER REAL PROPERTY			
RENTAL INCOME			
AUTOMOBILES (MAKE/YEAR)			
LIFE INSURANCE (FACE/CASH VALUES)			

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1.Where was the applicant residing for the past 12 months?________________________________

____

2.What was the applicant's legal address for the past 12 months? ___________________________

____

3. Has applicant utilized rehab, inpatient or outpatient services in another facility? Yes___ No ____

4.Has the applicant applied for Medicaid or intending to apply for Medicaid? Yes _____ No ______

If Yes, list Name, County & Telephone # of Medicaid Caseworker. ___________________________

____

5. Has the applicant or spouse transferred, given, or conveyed assets in the last 60 months?______

If so, please specify: ____

____

6. Does the applicant need to DISENROLL from an HMO? Yes ______ No ______

7. Does the applicant need to ENROLL in Medicare Part D? Yes ______ No ______

I agree to furnish on request certification as to my assets, income and sources of income. My spouse and/or designated representative also agree to provide financial information as may be required for application for Medicaid benefits. I agree to pay for my cost of care from my income and assets according to current rates set by the State of New York as long as I am a resident. When my funds are not enough, I agree to comply with eligibility requirements and will apply for State of New York Medicaid acceptance. I agree to provide a completed Burial Plan and means for paying the anticipated costs.

____

Signature **Date**

LONG ISLAND STATE VETERANS HOME

Physical & Medical History

State University of New York at Stony Brook
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____

Name of Applicant Date

MEDICAL HISTORY

(To be Completed by Physician)

Last Hospitalization: ____________________ *Admission Date* __________ *Discharge Date*___________________
Primary Diagnosis: ____
Secondary Diagnoses: ____
Reason for Hospitalization: ____

DISEASE DIAGNOSES/HEALTH CONDITIONS:

Check only those diseases present that have a relationship to the applicant's current ADLs, cognitive status, behavioral status, medical treatments, or risk of death. Please do not check old or inactive diagnoses.

HEART/CIRCULATION

___ Arteriosclerotic heart disease (ASHD)
___ Cardiac Dysrthythmia
___ Congestive heart failure
___ Hypertension
____ Hypotension
___ Peripheral vascular disease
___ Other cardiovascular disease

NEUROLOGICAL

___ Alzheimer's Disease
___ Dementia other than Alzheimer's
___ Aphasia
___ Multiple Sclerosis
___ Parkinson's disease
___ Emphysema/Asthma/COPD
___ Pneumonia

SENSORY

____Cataract
____ Glaucoma

EDEMA

_____ Edema – None
_____ Edema – Generalized
_____ Edema – Localized not pitting
_____ Edema _ Other

PROBLEM CONDITIONS & SIGNS/SYMPTOMS

Please check all that apply within the last 90 days

_____ Constipation
_____ Diarrhea
_____ Shortness of Breath
_____ Fever
_____ Hallucinations/Delusions
_____ Internal Bleeding
_____Joint Pain
_____ Pain (Daily/Almost Daily)
_____ Recurrent Lung Aspirations
_____Dizziness
_____ Fecal Impaction
_____ Vomiting
_____ Respiratory Infection
_____ Chest Pain
_____Syncope
_____Other ______________________________________
____
____

OTHER

_____Allegeries
_____ Anemia
_____ Arthritis
_____ Cancer
_____Diabetes Mellitus
_____ Hypothyroidism
_____ Osteoporosis
_____ Septicemia

ANY CONDITIONS RELATED TO MR/DD

Please explain any condition related to MR/DD

____
____
____

OTHER CURRENT CONDITIONS

____
____
____

MEDICATIONS:

____
____
____
____
____
____
____
____

ALLERGIES:

____
____

IMMUNIZATION HISTORY:

Pneumovax ____________ (Date) **Hepatitis B __________________(Date)**
Influenza ______________ (Date) **Tetanus _____________________(Date)**

PHYSICAL EXAMINATION

BP ___________
P ___________
R ___________
T ___________
Wt ___________
Ht ____________

LABS Including Blood, Urine, EKG, CXR, etc.)

Please provide copy of most recent

____
____
____
____
____
____

____________________________________ ____________________

Physician Signature Date
Physician Printed Name