

ADULT DAY HEALTH CARE
Long Island State Veterans Home
at Stony Brook University
100 Patriots Road
Stony Brook, New York 11790-3300

Application for Admission

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 Health 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 _____
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2. SEX	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Maiden Name _____
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3. PRESENT ADDRESS	Telephone # () _____
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3 a. CROSS STREET _____

4. How did you learn about the program? _____

5. Date of Birth _____	Age _____	Place of Birth _____
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6. MARTIAL STATUS	<input type="checkbox"/> Never Married	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
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7. Social Security # _____	Medicare # _____
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8. Medicaid # _____	County of Coverage _____	Overage _____
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9. Other Insurance _____

10. PRIMARY LANGUAGE	<input type="checkbox"/> English	Other (specify) _____
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11. RACE/ETHNICITY	<input type="checkbox"/> White	<input type="checkbox"/> White/Hispanic	<input type="checkbox"/> Black	<input type="checkbox"/> Black/Hispanic	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other
	<input type="checkbox"/> Asian/Pac. Islander/Hispanic	<input type="checkbox"/> Am. Indian/Alaskan Native	<input type="checkbox"/> Am. Indian/Alaskan Native/Hispanic			

12. ADVANCED DIRECTIVES	<input type="checkbox"/> Living Will	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Health Care Proxy _____
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13. LEGAL REPRESENTATIVES	<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Guardian	<input type="checkbox"/> Committee	<input type="checkbox"/> Other _____
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14. RELIGION _____

15. RESIDENTIAL STATUS	<input type="checkbox"/> Live Alone	<input type="checkbox"/> With Family	<input type="checkbox"/> Adult Home	<input type="checkbox"/> Other _____
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16. LIFETIME OCCUPATION _____

17. US CITIZEN	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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18. EDUCATION (Highest Completed):	<input type="checkbox"/> No Schooling	<input type="checkbox"/> 8th grade/less	<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> High School	<input type="checkbox"/> Tech./Trade School
	<input type="checkbox"/> Some College	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Graduate Degree		

19. War in which service was rendered _____	Date of entry into active duty _____
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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, marital 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.