Long Island State Veterans Home
AT STONY BROOK UNIVERSITY

Long Island State Veterans Home
100 Patriots Road
Stony Brook, NY 11790
Phone: (631) 444-8548 Fax: (631) 444-8573

Dear Applicant,

Thank you for your interest in the Long Island State Veterans Home. Our mission is dedicated to serving veterans and their families in a warm, supportive environment that provides the highest standards of quality care for both short term rehabilitation and long term services.

Often times the need for nursing home placement or rehabilitation services is immediate, allowing for little or no preparation time. You may be called upon to make important and emotionally difficult decisions regarding your loved one. Our caring and compassionate staff is comprised of highly trained and experienced professionals who are eager to assist you throughout the admissions process.

We are pleased to report that we are now a Tobacco-Free Campus. Breathe easy as tobacco products are not permitted on our 25 acre campus. Therefore we do not admit residents who wish to smoke or use tobacco products.

We welcome this opportunity to provide you with our application, brochure and mission statement. If you have additional questions, require more information or would like to schedule an appointment for a tour, we invite you to call us at (631) 444-8548. You can also visit our website at www.listateveteranshome.org.

Respectfully yours,

Lauren Mahoney

Lauren Mahoney
Director of Admissions

Long Island State Veterans Home Admission Application
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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.

Placement:

☐Short Term Rehab ☐ Long Term Care Requesting placement for: ☐Veteran ☐ Spouse/Widow

LISVH is a tobacco free facility. Have you smoked/used a tobacco product (including electronic cigarettes)? ☐Yes ☐No

If yes, when was the last time you smoked or used a tobacco product? _____

Basic Information:

Name of Applicant:_____ Phone Number:_____

Address:_____ City/State/Zip:_____

Birth Date:_____ Birth Place:_____ Social Security #:_____

Gender:_____ Religion:_____ Marital Status:_____

Race: (Please check all that apply)

☐White ☐Hispanic ☐Black or African American ☐American Indian or Native Alaskan

☐Asian ☐Native American or other Pacific Islander

Military Service:

Branch of Service:_____ Service Number:_____

Date of Entry:_____ Date of Discharge:_____ P.O.W._____ Purple Heart_____

Does this applicant have a service connected disability? ☐Yes ☐ No If yes, what percentage?_____

Contact(s):

Resident Representative:_____ Relationship:_____

Address:_____ City/State/Zip:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Additional Contact:_____ Relationship:_____

Address:_____ City/State/Zip:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Insurance:

HMO Enrolled? ☐Yes ☐No If yes, policy information_____

Medicare #_____ ☐Part A ☐Part B ☐Part D

Medicaid #_____ County_____

Medicaid Lawyer/Agency (if applicable)_____ Phone_____

Secondary Insurance:_____ Policy #:_____

Prescription Coverage:_____ Policy #:_____

Please provide a copy of Power of Attorney, Health Care Proxy, DNR, Living Will, Medicare Card, Insurance/Prescription Cards, Veteran Discharge Papers and Marriage/Death Certificate if applicable.

The Long Island State Veterans Home, in its financial planning, must have information about the financial ability of each applicant interested in placement at the Long Island State Veterans Home. Please provide the information requested below.

Income:

	Veteran	Spouse
Social Security:	$_____	$_____
Employer Pensions:	$_____	$_____
Union Pensions:	$_____	$_____
RR Retirement:	$_____	$_____
Veteran Benefits:	$_____	$_____
Trust:	$_____	$_____
Annuity:	$_____	$_____
Other Income:	$_____	$_____
IRA Distribution:	$_____	$_____

Resources:

	Veteran	Spouse
Checking Account:	$_____	$_____
Savings Account:	$_____	$_____
Other Accounts:	$_____	$_____
Stocks/Bonds:	$_____	$_____
Real Estate:	$_____	$_____
IRA/KEOGH/401K:	$_____	$_____
Life Insurance: (Face/Cash Value)	$_____	$_____
Own Home/Condo: (Cash Value)	$_____	$_____
Other:	$_____	$_____

- Has the applicant sold, gifted or transferred any cash, real estate or personal property within the past 60 months? ☐Yes ☐No If yes, please indicate asset type, value and date:_____
_____

- Is applicant expected to receive inheritance, lawsuit settlement or trust? ☐Yes ☐No

- Does the resident have a prepaid burial arrangement? ☐Yes ☐No
  If yes, please include a copy with your application.

- Has the applicant utilized rehab, inpatient or outpatient services? ☐Yes ☐No
  If yes, please provide the location(s) and date(s):
  Location:_____ Dates:_____
  Location:_____ Dates:_____
  Location:_____ Dates:_____

I agree to furnish on request certification as to my assets, income and sources of income. My spouse and/or resident 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.

X_____

Signature Relationship to Applicant Date

Physical & Medical History

ONLY HAVE A PHYSICIAN COMPLETE IF APPLICANT IS RESIDING AT HOME OR IN AN ASSISTED LIVING FACILITY

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Name of Applicant:_____ Date:_____

Last Hospitalization:_____ Admission Date:_____ Discharge Date:_____

Primary diagnosis:_____

Secondary diagnosis:_____

Reason for hospitalization:_____

Has the patient ever smoked? Yes____ No____ If yes, when was the last day_____

Disease Diagnoses/Health Conditions:

Please 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 dysrhythmia
- ___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

Respiratory
- ___Emphysema/Asthma/COPD
- ___Pneumonia

Sensory
- ___Cataract
- ___Glaucoma

Edema
- ___Edema – Generalized
- ___Edema – Localized not pitting
- ___Edema – Other

Problem conditions & signs/symptoms
- ___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
- ___Allergies
- ___Anemia
- ___Arthritis
- ___Cancer
- ___Diabetes Mellitus
- ___Hypothyroidism
- ___Osteoporosis
- ___Septicemia

Any conditions related to MR/DD (please explain)

_____
_____
_____

Other current conditions

_____
_____
_____

Medications: (Including over the counter)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

_____
_____
_____

Immunization History:

Pneumovax_____ (Date) Hepatitis B_____ (Date)

Influenza_____ (Date) Tetanus_____ (Date)

Physical Examination:

BP _____ T _____
P _____ Wt _____
R _____ Ht _____

Labs: (Including blood, urine, EKG, CXR, etc.) Please provide a copy of the most recent.

_____
_____
_____

_____ _____ _____

Physician Signature Physician Printed Name Date

Physician office phone number (including area code): _____