Adult Day Health Care
Long Island State Veterans Home Admission Application
100 Patriots Road
Stony Brook, NY 11790
Phone: (631) 444-8530 Fax: (631) 444-8534

Long Island State Veterans Home
AT STONY BROOK UNIVERSITY

LISVH does not discriminate based on race, creed, color, age, national origin, sex, disability, blindness, marital status, sponsorship or source of payment. LISVH admits and treats all registrants on a non-discriminatory basis. LISVH does not discriminate or permit discrimination, including, but not limited to, bullying, abuse, harassment, or differential treatment on the basis of actual or perceived sexual orientation, gender identity or expression, or HIV status, or based on association with another individual on account of that individual's actual or perceived sexual orientation, gender identity or expression, or HIV status. You may file a complaint with the office of the New York State Long-Term Care Ombudsman Program at 631-470-6755 if you believe that you have experienced this kind of discrimination.

Placement:

Requesting placement for: ☐Veteran ☐ Spouse/Widow ☐ Gold Star Parent

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 #:_____

Birth Sex:_____ Self-Identified Gender Identity:_____ Marital Status:_____

Religion:_____ Race: _____ Ethnicity: ☐Not Hispanic ☐Hispanic

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):

Registrant 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 #_____ Medicaid #_____ County_____

Secondary Insurance:_____ Policy #:_____

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

X_____

Signature Relationship to Applicant Date