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: ☐American Indian or Alaska Native ☐Asian ☐Black or African American

☐Native Hawaiian or other Pacific Islander ☐White 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):

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 (please indicate monthly 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

LONG ISLAND STATE VETERANS HOME
at Stony Brook University
100 Patriots Road, Stony Brook, New York 11790-3300
Phone: 631-444-8548 Fax: 631-444-8573

Immunization History

The Immunization History is **required** documentation for all Nursing Home applicants and residents. Please **complete each section** of this form & return to this office as soon as possible.

***Form can be completed by a Physician/Physician Assistant (if not documentation is required)**

Name of Applicant: _____ **Date**: _____

❑ See attached

Flu Vaccination: (*Within the Last Year Between August and April*)	❑ No ❑ Yes ❑ Unknown If yes, date received: _____ ❑ Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
Prevnar 13:	❑ No ❑ Yes ❑ Unknown If yes, date received: _____ ❑ Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
Pneumococcal 15:	❑ No ❑ Yes ❑ Unknown If yes, date received: _____ ❑ Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
Pneumococcal 20:	❑ No ❑ Yes ❑ Unknown If yes, date received: _____ ❑ Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
Pneumococcal 23:	❑ No ❑ Yes ❑Unknown If yes, date received: _____ ❑ Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician

COVID – 19 Information	
Has the applicant received a previous dose of the Pfizer, Moderna, Novavax, or Janssen COVID-19 vaccine? ❑ No ❑ Yes, if yes, please complete ***(Proof of Covid-19 Vaccination is Required)***	❑ Unknown
❑ Pfizer ❑ 1 Dose ❑ 2 Doses ❑ 1st Booster ❑ 2nd Booster ❑ Bivalent Booster (≥ 12 years old) ❑ Moderna ❑ 1 Dose ❑ 2 Doses ❑ 1st Booster ❑ 2nd Booster ❑ Bivalent Booster (≥ 18 years old) ❑ Novavax ❑ 1 Dose ❑ 2 Doses ❑ Janssen (Johnson & Johnson) ❑ 1 Dose ❑ 1st Booster ❑ 2nd Booster	

_____ _____
Name of Resident Designated / Resident Representative Date

_____
Signature of Resident Designated / Resident Representative

_____ _____ _____
Print Physician Name Physician Signature Date

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Medical History & Physical

The following **must be completed** by a Physician if applicant is living at Home or in an Assisted Living Facility

Name of Applicant: _____ **Date**: _____

Present Diagnosis / Conditions Please check only active Diseases/Conditions		
❑ Alzheimer's Disease ❑ Anemia ❑ Angina ❑ Anxiety ❑ Aphasia ❑ Arteriosclerotic Heart Disease ❑ Arthritis ❑ Atrial Fibrillation ❑ Benign Prostatic Hyperplasia ❑ Cancer, Specify type, _____ ❑ Cardiac Dysrhythmia ❑ Cataract ❑ Chest Pain ❑ Congestive Heart Failure ❑ Constipation ❑ CVA Late Effect: _____ ❑ Dementia other than Alzheimer's: Specify: _____	❑ Depression ❑ Diabetes ❑ Diarrhea ❑ Dizziness ❑ Emphysema ❑ Edema – Generalized ❑ Edema Localized not pitting ❑ Epilepsy ❑ Fecal Impaction ❑ Fever ❑ Glaucoma ❑ Hallucinations/ Delusions ❑ Hyperlipidemia ❑ Hypertension ❑ Hypotension ❑ Hypothyroidism ❑ Infectious Disease, specify _____ ❑ Joint Pain: Location:_____	❑ Liver Disease ❑ Multiple Sclerosis ❑ Osteoporosis ❑ Pain ❑ Daily ❑ Parkinson's Disease ❑ Peripheral Vascular Disease ❑ PTSD ❑ Recurrent Lung Aspirations ❑ Renal Disease ❑ Septicemia ❑ Shortness of Breath ❑ Syncope ❑ Total Hip Replacement, ❑ Left ❑ Right ❑ Both ❑ Total Knee Replacement, ❑ Left ❑ Right ❑ Both ❑ Vomiting

Recent Hospital Stay Date & Reason: _____

Recent Surgery: _____

Pacemaker: ❑ No ❑ Yes, if yes when, _____ **AICD**: ❑ No ❑ Yes, if yes when, _____

Allergies: ❑ NKA ❑ Yes, if yes, describe:
Medication: _____
Food: _____
Other: _____

Personal Habits:
Hx. of Alcohol Use: ❑ No ❑ Yes, if yes, describe _____
Hx. of Substance Abuse: ❑ No ❑ Yes, if yes, describe _____
Hx. of Smoking/Tobacco Use (including electronic cigarette): ❑ No ❑ Yes if yes, when did the applicant last smoke/use a tobacco product: _____

Upon completion, please fax to the Long Island State Veterans Home/Admission Department at 631-444-8573

Name of Applicant: _____

Immunization History: See Attached

Date of Last Physical Examination: _____

Physical Examination: Temp.:_____P:_____ R:_____ BP: _____ Height _____ Weight _____

Medication List: list Name, Dosage, Frequency (including over the counter medications) **OR** ❑ see Attached List

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Laboratory / Diagnostic Tests: _____

_____

_____

_____	_____	_____
Print Physician Name	Physician Signature	Date

_____

Physician Address

_____

Physician Phone Number

Upon completion, please fax to the Long Island State Veterans Home/Admission Department at 631-444-8573