Long Island State Veterans Home
AT STONY BROOK UNIVERSITY

Admissions Department
100 Patriots Road
Stony brook, NY 11790-3300
Phone: 631-444-8548 Fax: 631-444-8573
www.listateveteranshome.org

Dear Applicant:

Thank you for your interest in the Long Island State Veteran's 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 we are now a Smoke Free Campus. Breathe easy as smoking is not permitted on our 25 acre campus, therefore we do not admit residents who wish to smoke.

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,

Carole Zwycewicz

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Director of Admissions

Long Island State Veterans Home Admission Application

100 Patriots Road
Stony Brook, NY 11790
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LISVH does not discriminate based upon race, color, creed, age, blindness, sex, sexual preference, nation origin, marital status, disability, sponsorship or source of payment and retention and care of residents. LISVH is a SMOKE FREE facility.

Name of Applicant: _____ Phone Number:_____

Address: _____City/State/Zip: _____

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

Gender: ____ Religion: _____ Marital Status:_____ Are you a Smoker? Yes_____ No ____

Please check one of the following:

Race: White_____ White/Hispanic_____ Black_____ Black/Hispanic_____Other_____
Asian or Pacific Islander_____ Asian or Pacific Islander/Hispanic_____
American Indian or Alaskan Native_____ American Indian or Alaskan Native/Hispanic_____

Military Service: Branch: _____ Service Number: _____

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

Does applicant have service connected disability? Yes_____ No_____ Percentage_____

Emergency Contact: Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home # _____ Work # _____ Cell # _____

Name: _____ Relationship: _____

Address: _____ City/State: _____

Home # _____ Work # _____ Cell # _____

Insurance: HMO? Yes__ No__ If yes, policy information_____

Medicare #_____ Part A_____ Part B_____ Part D_____

Medicaid #_____ County_____

Medicaid Pending(Date Submitted):_____Lawyer/Agency_____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 and Veteran Discharge Papers

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

Income: (Check where applicable and provide monthly amounts)

	Veteran	Spouse
___Social Security:	$_____	$_____
___Employer Pensions:	$_____	$_____
___Union Pensions:	$_____	$_____
___RR Retirement:	$_____	$_____
___Veteran Benefits:	$_____	$_____
___Trust:	$_____	$_____
___Annuity:	$_____	$_____
___Other Income:	$_____	$_____
___Ira Distribution	$_____	$_____

Resources: (Check where applicable and provide current balance)

	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 explain: _____

- **Is applicant expected to receive inheritance, lawsuit settlement or trust? Yes_____ No_____**

- **Does the resident have a prepaid burial arrangement? Yes_____ No_____**
  Funeral Home: _____Address:_____
  Burial Plot: _____

- **Has Applicant utilized rehab, inpatient, or outpatient services in another facility? Yes_____ No_____**
  If Yes, please explain: _____

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.

X_____
Signature **Relationship to Applicant** **Date**

PLEASE COMPLETE IF APPLICANT IS LIVING At HOME OR IN ASSISTED LIVING

LONG ISLAND STATE VETERANS HOME Physical & Medical History

State University of New York at Stony Brook
100 Patriots Road
Stony Brook, New York 11790-3300

Name of Applicant _____ **Date**_____

MEDICAL HISTORY

(To be Completed by Physician)

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

Primary Diagnosis: _____

Secondary Diagnoses: _____

Reason for Hospitalization: _____

Have you every smoked: ↑ No ↑ Yes, when was the last day you smoked _____

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

_____ **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

_____**Allegories**
_____ **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 INCLUDING OVER THE COUNTER:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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 **Physician Printed Name** **Date**

Physician Office Phone Number including area code _____