

# Long Island State Veterans Home

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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](http://www.listateveteranshome.org).

Respectfully yours,

A handwritten signature in blue ink that reads "Lauren Mahoney".

Lauren Mahoney  
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, 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

**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

<b>Flu Vaccination:</b> <i>(Within the Last Year Between August and April)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>Prevnar 13:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>Pneumococcal 15:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>Pneumococcal 20:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>Pneumococcal 23:</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>Respiratory Syncytial Virus (RSV):</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, date received: _____ <input type="checkbox"/> Unknown Date Received	_____ Name/Address of Facility and/or Physician _____ Phone Number of Facility and/or Physician
<b>COVID – 19 Information</b>		
Has the applicant received a previous dose of COVID-19 vaccines? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, which product was administered? <b>(Proof of Covid-19 Vaccination is Required)</b> <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax <input type="checkbox"/> Janssen (Johnson & Johnson) <b>Monovalent Doses:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <b>Bivalent Doses:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <b>Spikevax/Moderna Dose:</b> <input type="checkbox"/> 1 <b>Comirnaty/Pfizer Dose:</b> <input type="checkbox"/> 1		<input type="checkbox"/> Unknown

\_\_\_\_\_  
Name of Resident Designated / Resident Representative \_\_\_\_\_ Date

\_\_\_\_\_  
Signature of Resident Designated / Resident Representative

\_\_\_\_\_  
Print Physician Name \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date

**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:** \_\_\_\_\_

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

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