Nursing Home Diversion Supportive Housing Program
Phone (631) 236-4325 ext. 3140
Fax (631) 514-3574
Email: NursingHomeDiversion@Fedoforg.org

Application

Section 1: General Information

First Name:_____ M.I._____ Last Name:_____

Date of Birth: _____ Phone Number: ( ) _____

Social Security Number:_____ E-mail: _____

Gender: _____ Preferred Language: _____ Marital Status: _____

Section 2: Entitlement Information

Medicaid #:_____***Medicaid number required
Medicare #: _____
Other Insurance: _____
SSI Amount: _____
SSDI Amount: _____
Public Assistance: _____
Food Stamps: _____
Other: _____**

Section 3: Current Living Situation *Please check one of the following

1. **Currently in Nursing Home _____**

Name: _____

Address: _____City: _____ State: _____ Zip Code: _____

OR

2. **Currently homeless: _____**

Provide current location of applicant or information of the shelter that applicant is residing:

_____

_____

OR

3. **Pending Homelessness_____**

Explain:_____

_____

Section 4: Medical Information

1. **List <u>ALL</u> medical conditions:**

   _____

   _____

   _____

   _____

   _____

2. **Name, address and telephone numbers of your treating physician(s) and specialist(s):**

   _____

   _____

   _____

   _____

   _____

3. **List all medical equipment necessary:**

   _____

   _____

   _____

   _____

   _____

4. **List current medications and dosages:**

   _____

   _____

   _____

   _____

5. **Briefly describe all hospitalizations in the past five years including hospital name, admission date, length of stay and reason for hospitalization:**

_____
_____
_____
_____
_____

Section 5: Preferences

1. **What county would applicant prefer to be housed in? (Check) Nassau_____ Suffolk_____**
2. **Necessary special accommodations:_____**

_____
_____

Section 6: Referral Information

3. **Referring Agency:_____ Contact Person: _____**
4. **Address:_____**
5. **Phone Number: (_____) _____ Email: _____**

In order to process application, please include:

- **Completed signed referral application**
- **Entitlements and Wage Verification i.e. Medicaid number, insurance cards, Social Security Award Letter, income information, additional financial assistance**
- **Provide any recent medical information**
- **Provide a Physician's Letter indicating applicant has a physical disability lasting 12 or more months**
- **If homeless, provide attestation of homelessness**
- **If applicable, provide Legal Guardian/Health Care Proxy/Power of Attorney paperwork**

Section 6: Completion & Signature

Applicant Signature_____ Date_____

Thank you for your application. A member of the Nursing Home Diversion Supportive Housing Program will contact you upon receipt of your application.

Updated 12/27/16