OCFS-LDSS-2949 (Rev. 7/2012)

NEW YORK STATE
OFFICE CHILDREN AND FAMILY SERVICES

PERSONAL DATA SHEET

FACILITY NAME	ROOM NO.

RESIDENT'S NAME *(Last, First, MI)*	DATE OF BIRTH	RELIGION	SEX ☐ M ☐ F	SOCIAL SECURITY NO.

NOTIFY IN CASE OF EMERGENCY			ATTENDING PHYSICIAN		
NAME			NAME		
STREET			STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
RELATIONSHIP	PHONE		PHONE	◀ Office Emergency ▶	PHONE
NAME			NAME		
STREET			STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PHONE	◀ Office Emergency ▶	PHONE	PHONE	◀ Office Emergency ▶	PHONE

HEALTH INSURANCE		
	POLICY NO.	TYPE
	POLICY NO.	TYPE

AREA HOSPITAL/CLINIC OF CHOICE	
	NAME
	ADDRESS *(Street, City, Zip Code)*

FAMILY INFORMATION

MARITAL STATUS:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Unknown

NAME OF RESIDENT'S REPRESENTATIVE		RELATIONSHIP:
STREET		
CITY	STATE	ZIP CODE
PHONE	◀ Office Emergency ▶	PHONE
BURIAL INSTRUCTIONS:		

ADMISSION/ DISCHARGE INFORMATION

ADMISSION DATE	**ADMITTED FROM** ☐ Own Home ☐ Hospital ☐ SNF ☐ HRF ☐ DCF ☐ DMH Facility ☐ Other *(specify)* _____	COUNTY

ADDRESS ADMISSION SPONSOR *(If any)*

RESIDENT'S ADMISSION SPONSOR *(If any)*

DISCHARGE DATE	ADMITTED FROM ☐ Own Home ☐ Hospital ☐ SNF ☐ HRF ☐ DMH Facility ☐ DCF ☐ Other *(specify)* _____

ADDRESS DISCHARGED TO *(Street, City, State, Zip Code)*

REASON FOR DISCHARGE

NOTIFIED LOCAL DEPARTMENT OF SOCIAL SERVICES ☐ **YES**

DATE:______________________________

NAME OF PERSON CONTACTED: