

**SLS Residential
Application for Services**



Insurance Information



(must be completed prior to admission if this is method of payment)

Medicare #

Medicaid #

Private Insurance Carrier

ID #

Group #

Policy Holder Name

Relation to Applicant

Policy Holder DOB

Policy Holder SS #

Customer Service Telephone #

Prescription Carrier

ID #

Group #

BIN #

Customer Service Telephone #

If No Prescription Plan Coverage, mail bills to:

Address

City

State

Zip

No candidate will be discriminated against because of race, color, religion, sex or national origin.

Application to be sent to:

**SLS Residential
Intake Department
2505 Carmel Avenue
Suite 210
Brewster, NY 10509**

Physical Exam



TO BE COMPLETED BY A LICENSED PHYSICIAN

Name _____ Date _____

DOB _____ SEX _____ Weight _____ Height _____ BP _____ Pulse _____

TB Skin Result _____ Urinalysis Result _____

Allergies _____

Eyes _____ Ears _____ Nose _____ Neck _____

Lymphatic _____ Chest & Lungs _____ Heart _____

Abdomen _____ Genito-Urinary _____ Hernia _____

Mouth _____ Musculo-Skeletal _____ Vascular _____

Vision _____ R: _____ L: _____ Hearing _____ R: _____ L: _____

Neurological _____

Physical Limitations _____

Current Medications _____

Other (specify) _____

Recommendations _____

Physician Signature _____ Print Name _____ Date _____

