NEW YORK STATE DEPARTMENT OF HEALTH
Office of Aging and Long Term Care

Adult Care Facility
Chronological Admission and Discharge Register

Facility Name _____ **Operating Certificate Number** _____

Period Covered From _____ To _____ Page Number _____ of _____

Admission Codes*

1 – Hospital
2 – Own Home
3 – Skilled Nursing Facility (SNF)
4 – Another Adult Home/Enriched Housing Program
5 – State Development Center
6 – State Psychiatric Center
7 – Transfer from another unit of this facility
8 – Death
9 – Other (specify) _____

Ethnicity

1 – No, not of Hispanic, Latino/a, or Spanish Origin
2 – Yes, Mexican, Mexican American, Chicano/a
3 – Yes, Puerto Rican
4 – Yes, Cuban
5 – Yes, Another Hispanic, Latino/a or Spanish Origin
6 – Prefer not say

Level of Care (LOC) Codes*

AH – Adult Home
ALP – Assisted Living Program
ALR – Assisted Living Residence
EALR – Enhanced Assisted Living Residence
EHP – Enriched Housing Program (EHP)
SNALR – Special Needs Assisted Living Residence

Race

1 – White
2 – Black or African
3 – American Indian/ or Alaska Native
4 – Asian Indian
5 – Chinese
6 – Filipino
7 – Japanese
8 – Korean
9 – White
10 – Other Asian
11 – Native Hawaiian
12 – Gurmanian
13 – Chamorro
14 – Samoan
15 – Other _____

Date	Resident's Name	Age	Race	Ethnicity	Sex	LOC**	Admitted From	Discharged To	Facility and Address Admitted From or Discharged To

Date	Resident's Name	Age	Race	Ethnicity	Sex	LOC**	Admitted From	Discharged To	Facility and Address Admitted From or Discharged To