NEW YORK STATE
OFFICE CHILDREN AND FAMILY SERVICES

PERSONAL DATA SHEET

FACILITY NAME			
RESIDENT'S NAME *(Last, First, MI)*	DATE OF BIRTH / /	RELIGION (if applicable)	SOCIAL SECURITY NO.

NOTIFY IN CASE OF EMERGENCY			**PRIMARY CARE PHYSICIAN**		
NAME	RELATIONSHIP:		NAME		
STREET			STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PHONE ◀ **Office Emergency** ▶	PHONE		PHONE ◀ **Office Emergency** ▶	PHONE	

(Declining to provide racial, ethnic, sexual orientation or gender identity information does not affect consideration of an application.)

SEX

☐ Male
☐ Female
☐ X
☐ Declined
☐ Other

PRIMARY LANGUAGE

1 - Arabic
2 - Bengali
3 - Chinese
4 - English
5 - French
6 - Haitian Creole
7 - Italian
8 - Korean
9 - Polish
10 - Russian
11 - Spanish
12 - Urdu
12 - Yiddish
13 - Other

RACE

☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Black or African American
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ Declined
☐ Unknown
☐ Other

RACIAL ANCESTRY

☐ Asian Indian
☐ Bangladeshi
☐ Burmese
☐ Chinese
☐ Filipino
☐ Guamanian and Chamorro
☐ Japanese
☐ Korean
☐ Nepalese
☐ Pakistani
☐ Samoan
☐ Thai
☐ Vietnamese
☐ Declined
☐ Unknown
☐ Other

FAMILY INFORMATION

MARITAL STATUS:
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Unknown

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

PRIMARY HEALTH INSURANCE

NAME OF INSURANCE CARRIER	TYPE
PHONE	POLICY NUMBER

AREA HOSPITAL/CLINIC OF CHOICE

NAME

ADDRESS *(Street, City, Zip Code)*

ADMISSION/ DISCHARGE INFORMATION

ADMISSION DATE / /	ADMITTED FROM ☐ Own Home ☐ Hospital ☐ Skilled Nursing Facility ☐ Health Related Facility ☐ Other (specify) ____	NAME OF FACILITY (if applicable)
FORMER HOME ADDRESS OR FACILITY ADDRESS		
NAME OF FACILITY CONTACT PERSON (if applicable		
DISCHARGE DATE / /	DISCHARGE TO ☐ Own Home ☐ Hospital ☐ Skilled Nursing Facility ☐ Health Related Facility ☐ 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:		