NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

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)

Level of Care (LOC) Codes*

AH – Adult Home
ALP – Assisted Living Program
A – Assisted Living Residence
E – Enhanced Assisted Living Residence
EHP – Enriched Housing Program (EHP)
S – Special Needs Assisted Living Residence

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

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