beyond the last quarter of the preceding Federal fiscal year), then the State applicant will be notified in writing that the application for VA assistance will be deemed withdrawn and no further action will be taken.

(Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–0709)

[73 FR 73560, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

§ 53.30 Payments.

(a) The amount of payments awarded under this part during a Federal fiscal year will be the amount requested by the State and approved by VA in accordance with this part. Payments may not exceed 50 percent of the cost of the employee incentive program for that fiscal year and may not exceed 2 percent of the amount of the total per diem payments estimated by VA to be made under 38 U.S.C. 1741 to the State for that SVH during that fiscal year for adult day health care, domiciliary care, hospital care, and nursing home care.

(b) Payments will be made by lump sum or installment as deemed appropriate by the Director, Geriatrics and Extended Care Operations.

(c) Payments will be made to the State or, if designated by the State representative, the SVH conducting the employee incentive program.

(d) Payments made under this part for a specific employee incentive program shall be used solely for that purpose.

(Authority: 38 U.S.C. 101, 501, 1744)

[73 FR 73560, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

§ 53.31 Annual report.

(a) A State receiving payment under this part shall provide to VA a report setting forth in detail the use of the funds, including a descriptive analysis of how effective the employee incentive program has been in improving nurse staffing in the SVH. The report shall be provided to VA within 60 days of the close of the Federal fiscal year (September 30) in which payment was made and shall be subject to audit by VA.

(b) A State receiving payment under this part shall also prepare audit reports as required by the Single Audit Act of 1984 (see 38 CFR part 41) and submit them to VA.

(Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–0709)

§ 53.32 Recapture provisions.

If a State fails to use the funds provided under this part for the purpose for which payment was made or receives more than is allowed under this part, the United States shall be entitled to recover from the State the amount not used for such purpose or the excess amount received.

(Authority: 38 U.S.C. 101, 501, 1744)

§ 53.40 Submissions of information and documents.

All submissions of information and documents required to be presented to VA must be made to the Director, Geriatrics and Extended Care Operations, VHA Headquarters, 810 Vermont Avenue, NW., Washington, DC 20420.

(Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–0709)

[73 FR 73560, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

§ 53.41 Notification of funding decision.

If the Director, Geriatrics and Extended Care Operation, determines that a submission from a State fails to meet the requirements of this part for funding, the Director shall provide written notice of the decision and the reasons for the decision.

(Authority: 38 U.S.C. 101, 501, 1744)

[73 FR 73560, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

PART 58—FORMS

Sec.

AUTHORITY: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

SOURCE: 65 FR 981, Jan. 6, 2000, unless otherwise noted.

§ 58.10 VA Form 10–3567—State Home Inspection Staffing Profile.

OMB Approved No. 2900-0160
Estimated Burden Avg. 20 min.

Department of Veterans Affairs

STATE HOME INSPECTION

NAME OF HOME	DATE OF INSPECTION

PART I	TOTAL FACILITY	HOSPITAL	NHC	DOM
OPERATING BEDS				
AUTHORIZED APPROVALS				
PATIENT CENSUS				
POSITIONS AUTHORIZED				
STAFF AVAILABLE				
PART II - STAFF	**TOTAL FACILITY**	**HOSPITAL**	**NHC**	**DOM**
PHYSICIANS:				
PHYSICIANS ASSISTANTS				
DENTISTS				
SOCIAL WORK: MSW				
BSW				
SOCIAL WORK ASSISTANT				
PHARMACY: REG. PHARMACIST				
DIETETICS: REG. DIETITIAN				
FOOD SUPERVISOR				
DIETARY ASSISTANTS				
NURSING:				
NURSING ADM./SUP.				
DIRECT CARE: CERT. N.P./C.N.S.				
R.N.				
L.P.N./L.V.N.				
N.A.				
REHABILITATION THERAPY				
REG. P.T./P.T. AIDES				
REG. O.T./O.T. AIDES				
MENTAL HEALTH: PSYCHOLOGIST				
PSYCHIATRIST				
PSYCHIATRIC SOCIAL WORKER				
COUNSELOR				
SPEECH AND AUDIOLOGY				
OPHTHALMOLOGY/OPTOMETRY				
PODIATRY				
RADIOLOGY/LABORATORY				
RECREATION/ACTIVITIES				
DIRECTOR				
ASSISTANTS				
VOLUNTEERS				
CHAPLAIN				
ADMINISTRATION				
ENGINEERING				
MAINTENANCE/HOUSEKEEPING				
MEDICAL RECORDS				
OTHER *(Specify)*				

VA FORM MAY 1998 (RS) **10-3567** **SEE REVERSE**

NAME OF HOME	DATE OF INSPECTION

NURSING SERVICE STAFFING PATTERN

(Four Week Average)

PART III — **HOSPITAL** ***(Average hours Hosp. _____)***

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

PART IV — **NURSING HOME** ***(Average hours NHC _____)***

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

PART V — **DOMICILIARY** ***(Average hours Dom. _____)***

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

NAME OF HOME	DATE OF INSPECTION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

VA FORM MAY 1998 (RS) **10-3567** **PAGE 3**

§ 58.11 VA Form 10–5588—State Home Report and Statement of Federal Aid Claimed.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

1. USE OF VA FORM 10-5588, STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

The VA Form 10-5588 consists of several parts. This report is a monthly statement of gains and losses, days of care, average daily census, total per diem cost, per diem claimed and total amount claimed for hospital, nursing home, domiciliary, and adult day health care. The State home will be paid monthly. Payments will be made only after the State submits a completed VA Form 10-5588.

a. One copy of the monthly statement of account will be submitted by each State home to VA medical center of jurisdiction by the end of the 5th workday after the close of each monthly report period.

b. VA medical center of jurisdiction staff will review each monthly report for accuracy, resolve any discrepancies with the State home, make payment by electronic fund transfer and file the report. A report should not be accepted by a VA medical center staff if the report is incomplete (i.e., all appropriate blanks are complete and report is signed by the State home administrator and State employee when under management contract arrangement).

c. The original monthly statement will be verified and signed by the VA medical center staff person assigned as the point of contact for oversight of the State Home Program and forwarded in duplicate to the Business Office for audit and payment. On completion of VA accounting certification, one copy of each report will be sent to VA Central Office, not later than the 15th workday after the month ends. This information is used to prepare the quarterly program reports of expenditures that are the basis or long range budget projections. The VA Central Office copy will be addressed to: Chief Consultant/Chief State Home Per Diem Program, Office of Geriatrics and Extended Care (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420.

2. GENERAL INSTRUCTIONS

a. Enter the last day of the calendar month covered by the report in the box labeled "For Month Ending."

b. Enter line entries for domiciliary, column A; nursing home, column B; hospital, column C; or adult day health care, column D in appropriate columns.

c. Lines 1 through 13 are to be completed for each level of care. Lines 1-9 will be completed as a monthly veteran residents accountability. Lines 10- 13 will be completed as the end of month resident accountability.

(1) Line 1, Total Veteran Residents Remaining End of Prior Month. Enter the number of veteran eligible residents present and remaining on the rolls of the State home as of midnight on the last day of the prior month. Entries on this line will be the same as those shown on line 9 for the prior month.

(2) Line 2, Admissions (Change of Status). Enter the number of eligible veterans whose status was changed by transfer from one level of care to another.

(3) Line 3, Admissions (Other). Enter the number of eligible veterans admitted to the State home during the report month.

(4) Line 4, Return From Leave of Absence of 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year.

(5) Line 5, Discharges (Change of Status). Enter the number of eligible veterans whose status was changed by transfer to another level of care in the State home. The total entries on line 2 and 5 for the month will be the same.

(6) Line 6, Discharges (Others). Enter the number of eligible veterans who were discharged from the State home or dropped from the rolls, except for deaths.

(7) Line 7, Deaths. Enter the number of eligible veterans who died during the report month. Attach a separate sheet to identify deaths by name.

(8) Line 8, Leave of Absence of 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year

(9) Line 9, Total Veteran Residents Remaining End of Month. Enter the number of eligible male and female veterans present and remaining as of midnight on the last day of the report month. This entry will be equal to the sum of lines 1, 2, 3 and 4 minus lines 5, 6, 7 and 8.

(10) Line 10, Non-Veteran Residents Remaining End of Month. Enter number of residents not eligible for reimbursement by VA that are present on the last day of the report month. DO NOT REPORT eligible veteran residents in this cell.

(11) Line 11, Total Nursing Home Care Veterans that are 70% Disabled or Admitted for a Service Connected Condition. Enter number of residents included on line 9, that are over 70% service connected disabled or admitted for a service connected condition.

(12) Line 12, Female Veteran Residents Remaining at the end of the month.

VA FORM JUL 2008 **10-5588**

CONTINUED INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID

(13) Line 13, Total Veteran Days of Care Provided. Enter total number of days of care provided, including days of care for eligible veterans absent 96 hours or less. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care. When accounting for Nursing Home Care use lines 13a and 13b.

(13a) Line 13a, Total Veteran Days of Care Provided for Nursing Home Care. Enter total number of days of care provided to veterans 70% or more disabled or admitted for a service connected disability, including days of care for eligible veterans with leave of absence of 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care.

3. INSTRUCTIONS FOR MONTHLY SUMMARY STATEMENT ACCOUNT.

a. Column E, Days of Care, Lines 14, 15, 16, and 17. Enter from line 13 the data in columns A for domiciliary, C for hospital care and D for adult day health care to show the total number of days for each level of care for the month. Enter from line 13b for B for nursing home care to show the total number of day for Nursing home Care for patients less than 70% service disabled or not admitted for a service connected condition. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care.

b. Column F, Average Daily Census, Lines 14, 15, 16, and 17. Enter the average daily census computed by dividing the appropriate entry in column J by the number of calendar days in the month, carried to one decimal place.

c. Column G, Total Per Diem Cost, Lines 14, 15, 16, and 17. Enter on the appropriate line the total per diem costs for the month computed in accordance with relevant cost principles set forth in the Office of Management and Budget(OMB) Circular number A-87, dated May 4, 1995, "Cost Principles for State, Local, and Indian Tribal Governments." The total per diem cost will include the direct and indirect costs appropriate for each level of care.

d. Column H, Per Diem Claimed, 14, 15, 16, and 17. Enter the authorized (VA approved per diem rate for the Fiscal Year) per diem rate or one-half the amount shown in column L carried to two decimal places whichever is the lesser, for the appropriate level of care. VA will pay monthly one-half of the cost of each eligible veteran's care (domiciliary, nursing home, hospital or adult day health care) for each day the veteran is in a facility recognized as a State home, not to exceed the approved per diem rate for that level of care.

e. Column I, Total Amount Claimed.

(1) Line 18. Verify that the total amount claimed in line 17 does not exceed one-half the sum of products of entries in columns E and I, lines 14, 15, 16 and 17.

4. INSTRUCTIONS FOR CLAIM PER DIEM PAYMENTS OF 70% SC VETERANS IN STATE NURSING HOMES.

a. Column J, Days of Care, Lines 19 and 20 total number of days for each level of care for the month. Including days of care for eligible veterans absent 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care. Total on line 21.

b. Column K, Total Veterans, Lines 19 and 20. Enter the total number of eligible veterans present on the last day of the report month on line 21.

c. Column L, Rate Per Day of SC Vet, 19 and 20. Use prevailing rate chart or (G) 15, whichever is less.

d. Column M, Amount Claimed, Lines 19 and 20. Enter the total amount by adding line 19 to line 20.

5. OPERATING BEDS

a. At the end of each month, State home management will enter the current operating bed capacities for domiciliary, nursing home, hospital or adult day health care in the appropriate spaces on Page 2 of the report form.b. Also on Page 2, facility management will enter bed capacities approved by VA. The approved bed capacity and the operating beds should be the same number of beds. If operating beds are closed for any reason, facility management is required to provide the date of closure, expected date the beds will be operational, type of bed (domiciliary, nursing home, hospital, or adult day health care), and the reason for the closure. Please specify if these beds were constructed with federal funds. Information related to closed beds may be entered under "Remarks".

6. CERTIFICATION

a. The facility management must certify that the information in the report is correct by signing and dating the report.

b. If the facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time, on site basis. This State employee must also certify that the information in the report is correct by signing and dating the report.

VA FORM JUL 2008 **10-5588**

Department of Veterans Affairs — **STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED**

TO	VA FACILITY	FROM	NAME AND ADDRESS OF STATE HOME
PAY TO		FOR MONTH ENDING	

CHANGES IN RESIDENCY FOR THE MONTH

LINE NO.	ITEM		DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
1	TOTAL VETERAN RESIDENTS REMAINING AT END OF PRIOR MONTH					
2	GAINS	ADMISSIONS *(Change of status)*				
3		ADMISSIONS *(Other)*				
4		RETURNS FROM LEAVE OF ABSENCE				
5	LOSSES	DISCHARGES *(Change of status)*				
6		DISCHARGES *(Other)*				
7		DEATHS				
8		LEAVES OF ABSENCE				
9	TOTAL VETERAN RESIDENTS AT END OF THE MONTH					

STATUS AS OF THE END OF THE MONTH

LINE NO.	ITEM	DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
10	TOTAL NON-VETERAN RESIDENTS AT THE END OF THE MONTH				
11	TOTAL NURSING HOME CARE VETS THAT ARE 70% OR MORE SC OR IN NEED OF NH CARE FOR A SC CONDITION				
12	FEMALE VETERAN RESIDENTS REMAINING AT THE END OF THE MONTH				

TOTAL DAYS OF CARE FOR THE MONTH

LINE NO.	ITEM	DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
13	TOTAL DAYS OF CARE FURNISHED TO VETERANS WHO ARE ELIGIBLE FOR PER DIEM PAYMENTS (*Excluding 13a*)				
13a	TOTAL DAYS OF CARE FURNISHED TO VETERANS 70% OR MORE SC OR IN NEED OF CARE FOR A SC CONDITION				

VA FORM JUL 2008 **10-5588**

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

CLAIM FOR BASIC PER DIEM PAYMENTS FOR ELIGIBLE VETERANS

LINE NO.	FEDERAL AID CLAIMED UNDER SEC.1741, TITLE 38, U.S.C., AS AMENDED	DAYS OF CARE (E)	AVERAGE DAILY CENSUS (F)	DAILY COST OF CARE FOR THE MONTH* (G)	PER DIEM CLAIMED (H)	TOTAL AMOUNT CLAIMED (I)
14	DOMICILIARY CARE					
15	NURSING HOME					
16	HOSPITAL CARE					
17	ADULT DAY HEALTH CARE					
18	TOTAL AMOUNT CLAIMED					

CLAIM FOR PER DIEM PAYMENTS FOR CERTAIN SC VETERANS IN STATE NURSING HOMES

LINE NO.	VETERAN CATEGORY	DAYS OF CARE (J)	AVERAGE DAILY CENSUS (K)	PREVAILING RATE FROM CHART OR (G) 15 WHICHEVER IS LESS (L)	AMOUNT CLAIMED (M)
19	HAS A SINGULAR OR COMBINED RATING OF 70% OR MORE BASED ON 1 OR MORE SERVICE-CONNECTED DISABILITIES OR A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY				
20	IS IN NEED OF NH CARE FOR A VA ADJUDICATED SC DISABILITY				
21	TOTALS:				

FOR UNITED STATES DEPARTMENT OF VETERANS AFFAIRS USE ONLY

I certify that this report is correct based on documentation provided to VA and that the bed capacity approved by VA is correct.

BED CAPACITY APPROVED BY VA

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

RECEIVING REPORT

- Services authorized under provisions of Sec. 1741, 1742, 1743 and 1745, Title 38, U.S.C., have been rendered in the quantity claimed and payment is recommended except as follows:

TOTAL AMOUNT APPROVED BY VA FOR PAYMENT (add block 18i and 21M)

SIGNATURE AND TITLE OF VA STATE HOME COORDINATOR | DATE

ACCOUNTING CERTIFICATION - AUDIT BLOCK

AMOUNT DUE | DATE | VOUCHER AUDITOR

SIGNATURE AND TITLE OF AUDITOR | DATE

The daily cost of care per veteran is the direct cost plus the indirect cost for the month, divided by patients or residents days of care. Compute this cost in accordance with relevant cost principles set forth in the Office of Management and Budget (OMB) Circular number A-87, dated May 4, 1995, Cost Principles for State, Local, and Indian Tribal Governments.

VA FORM JUL 2008 **10-5588**

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

TOTAL STATE OPERATING BEDS AT END OF THE MONTH

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

I certify that this report is correct, that all residents included in the report were physically present during the period for which Federal aid is claimed, except for authorized absences of 96 hours or less, and that facility management has complied with all provisions of Title VI, Public Law 88-352, entitled Civil Rights Act of 1964.

SIGNATURE OF STATE HOME ADMINISTRATOR	DATE

SIGNATURE OF STATE EMPLOYEE WHEN APPLICABLE	DATE

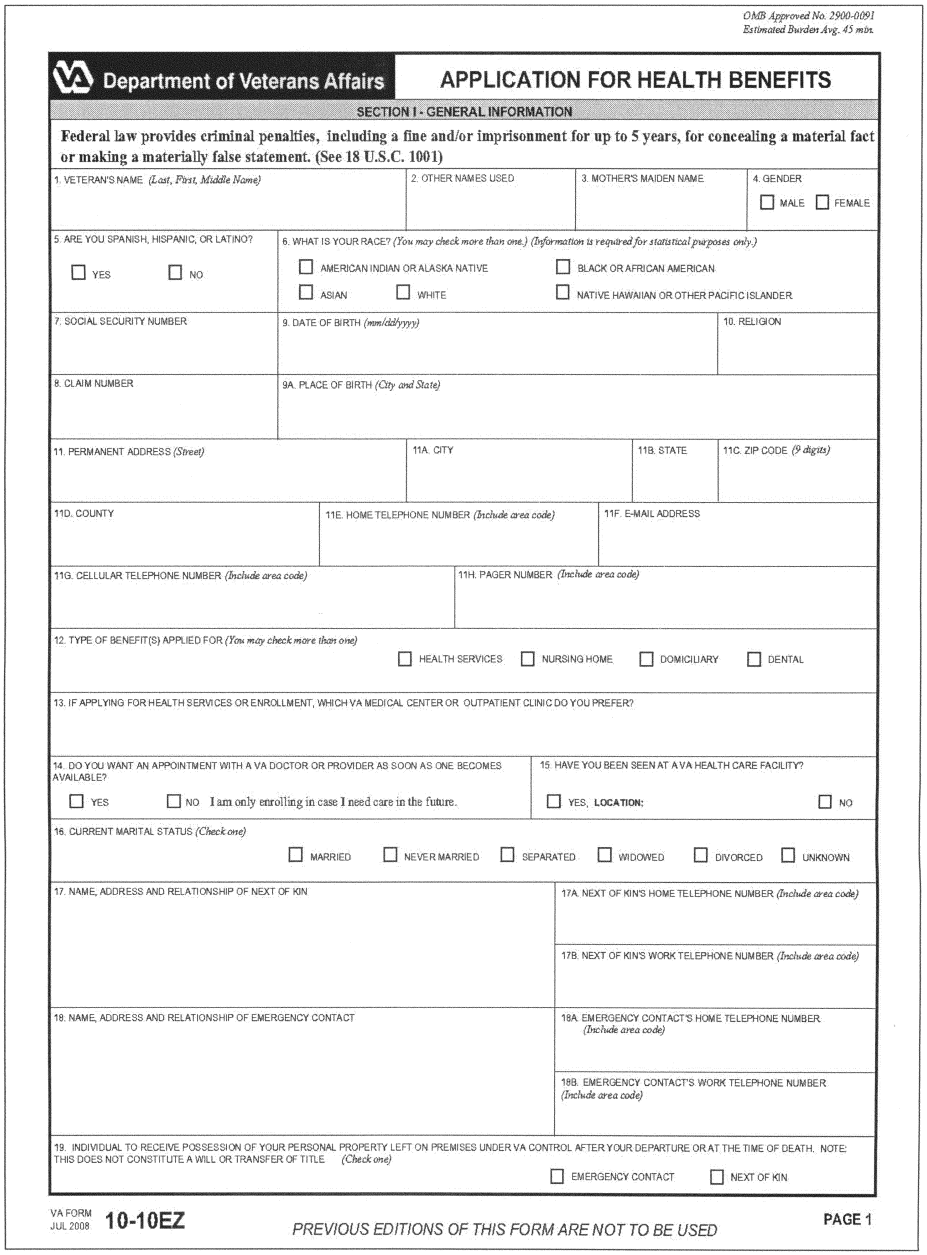
REMARKS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. Although completion of this form is voluntary, VA will be unable to provide reimbursement for services rendered without a completed form. Failure to complete the form will have no effect on any other benefits to which you may be entitled. This information is collected under the authority of Title 38 CFR Parts 51 and 52.

VA FORM JUL 2008 **10-5588**

[65 FR 981, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

§ 58.12 VA Forms 10–10EZ and 10–10EZR—Application for Health Benefits and Renewal Form.



OMB Approved No. 2900-0091
Estimated Burden Avg. 45 mtn.

Department of Veterans Affairs — **APPLICATION FOR HEALTH BENEFITS**

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME *(Last, First, Middle Name)*	2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH *(mm/dd/yyyy)*	10. RELIGION
8. CLAIM NUMBER	9A. PLACE OF BIRTH *(City and State)*	

11. PERMANENT ADDRESS *(Street)*	11A. CITY	11B. STATE	11C. ZIP CODE *(9 digits)*
11D. COUNTY	11E. HOME TELEPHONE NUMBER *(Include area code)*	11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER *(Include area code)*	11H. PAGER NUMBER *(Include area code)*		

12. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)* ☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?

14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.	15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? ☐ YES, **LOCATION:** ☐ NO

16. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	17A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
	17B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
	18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE. *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

VA FORM JUL 2008 **10-10EZ** *PREVIOUS EDITIONS OF THIS FORM ARE NOT TO BE USED* **PAGE 1**

APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER

SECTION II - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO			2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER			
4. POLICY NUMBER	5. GROUP CODE		
	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO			12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED *If employed or retired, complete item 1A* *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED *If employed or retired, complete item 2A* *Date of retirement (mm/dd/yyyy)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

VA FORM JUL 2008 **10-10EZ** PAGE 2

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. **Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information** but like other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through X.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have a special eligibility factor (e.g., recently discharged combat veteran, compensable service connection, receipt of VA pension or Medicaid benefits.) If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XII.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable sections VII through X. *Sign and date the form in Section XII.*

SECTION VII - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

SECTION VIII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(eg., Social Security, compensation, pension interest, dividends)*, EXCLUDING WELFARE	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VII.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION X - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

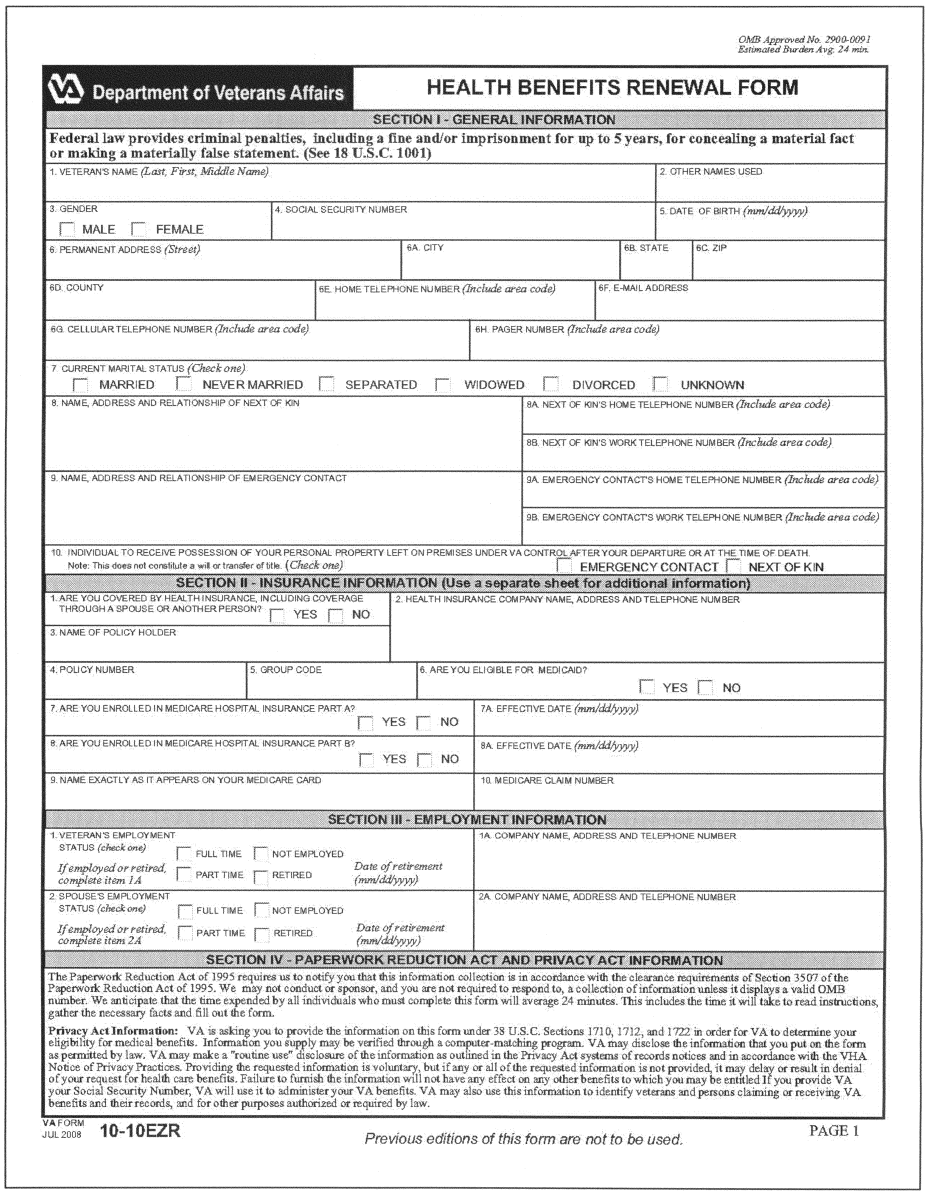
SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE

VA FORM JUL 2008 **10-10EZ** PAGE 3



OMB Approved No. 2900-0091
Estimated Burden Avg. 24 min.

Department of Veterans Affairs — **HEALTH BENEFITS RENEWAL FORM**

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME *(Last, First, Middle Name)* | 2. OTHER NAMES USED

3. GENDER ☐ MALE ☐ FEMALE | 4. SOCIAL SECURITY NUMBER | 5. DATE OF BIRTH *(mm/dd/yyyy)*

6. PERMANENT ADDRESS *(Street)* | 6A. CITY | 6B. STATE | 6C. ZIP

6D. COUNTY | 6E. HOME TELEPHONE NUMBER *(Include area code)* | 6F. E-MAIL ADDRESS

6G. CELLULAR TELEPHONE NUMBER *(Include area code)* | 6H. PAGER NUMBER *(Include area code)*

7. CURRENT MARITAL STATUS *(Check one)*
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

8. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN | 8A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)* | 8B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*

9. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT | 9A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)* | 9B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

10. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH.
Note: This does not constitute a will or transfer of title. *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE, INCLUDING COVERAGE THROUGH A SPOUSE OR ANOTHER PERSON? ☐ YES ☐ NO | 2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

3. NAME OF POLICY HOLDER

4. POLICY NUMBER | 5. GROUP CODE | 6. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO

7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO | 7A. EFFECTIVE DATE *(mm/dd/yyyy)*

8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? ☐ YES ☐ NO | 8A. EFFECTIVE DATE *(mm/dd/yyyy)*

9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD | 10. MEDICARE CLAIM NUMBER

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(check one)* ☐ FULL TIME ☐ NOT EMPLOYED
If employed or retired, complete item 1A ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*
| 1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

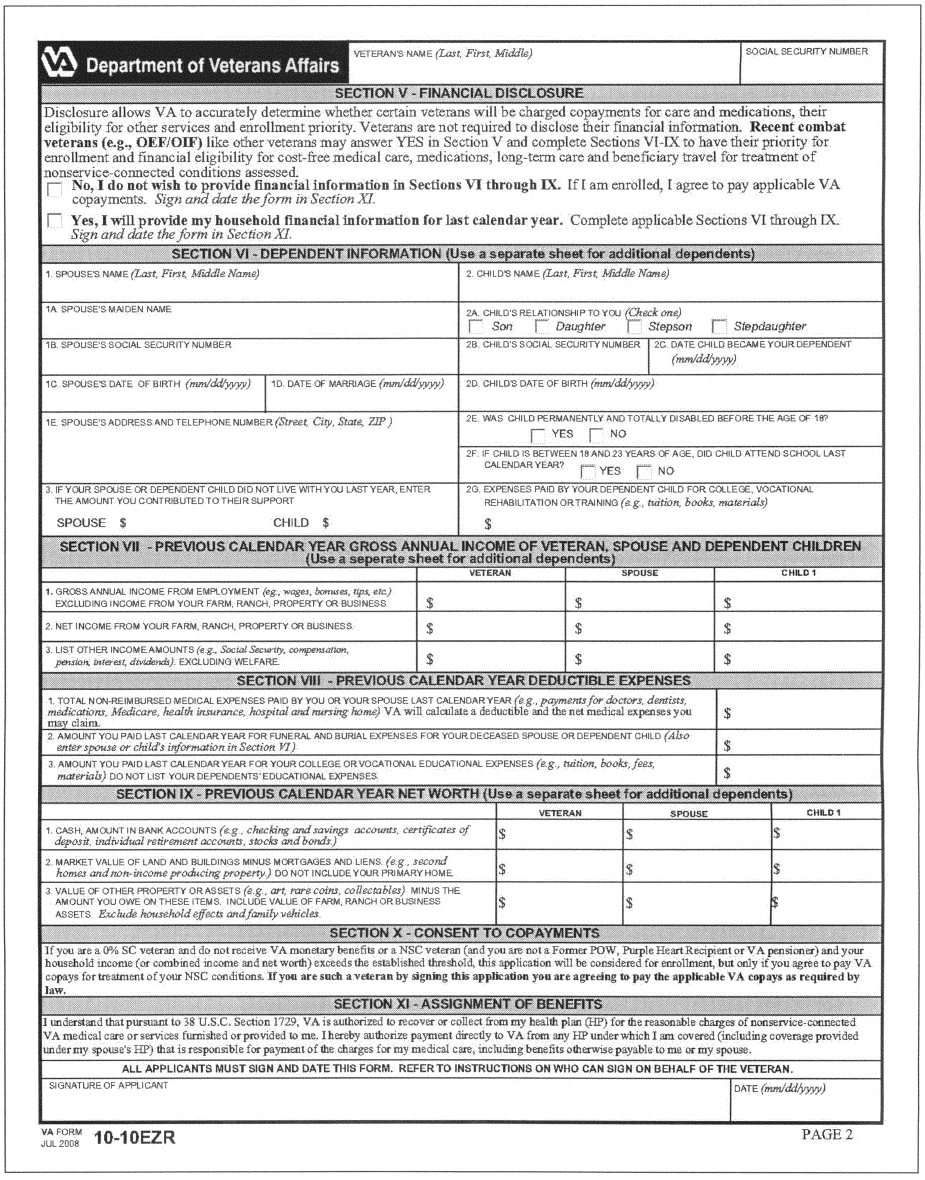
2. SPOUSE'S EMPLOYMENT STATUS *(check one)* ☐ FULL TIME ☐ NOT EMPLOYED
If employed or retired, complete item 2A ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*
| 2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 24 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

VA FORM JUL 2008 **10-10EZR** *Previous editions of this form are not to be used.* PAGE 1



Department of Veterans Affairs

VETERAN'S NAME *(Last, First, Middle)* | SOCIAL SECURITY NUMBER

SECTION V - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. **Recent combat veterans (e.g., OEF/OIF)** like other veterans may answer YES in Section V and complete Sections VI-IX to have their priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of nonservice-connected conditions assessed.

☐ **No, I do not wish to provide financial information in Sections VI through IX.** If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XI.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VI through IX. *Sign and date the form in Section XI.*

SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a seperate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(eg., wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS.	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS.	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)*. EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE LAST CALENDAR YEAR *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)* VA will calculate a deductible and the net medical expenses you may claim.	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials)* DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	$

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds.)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property.)* DO NOT INCLUDE YOUR PRIMARY HOME.	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)*. MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION X - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copays for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copays as required by law.**

SECTION XI - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

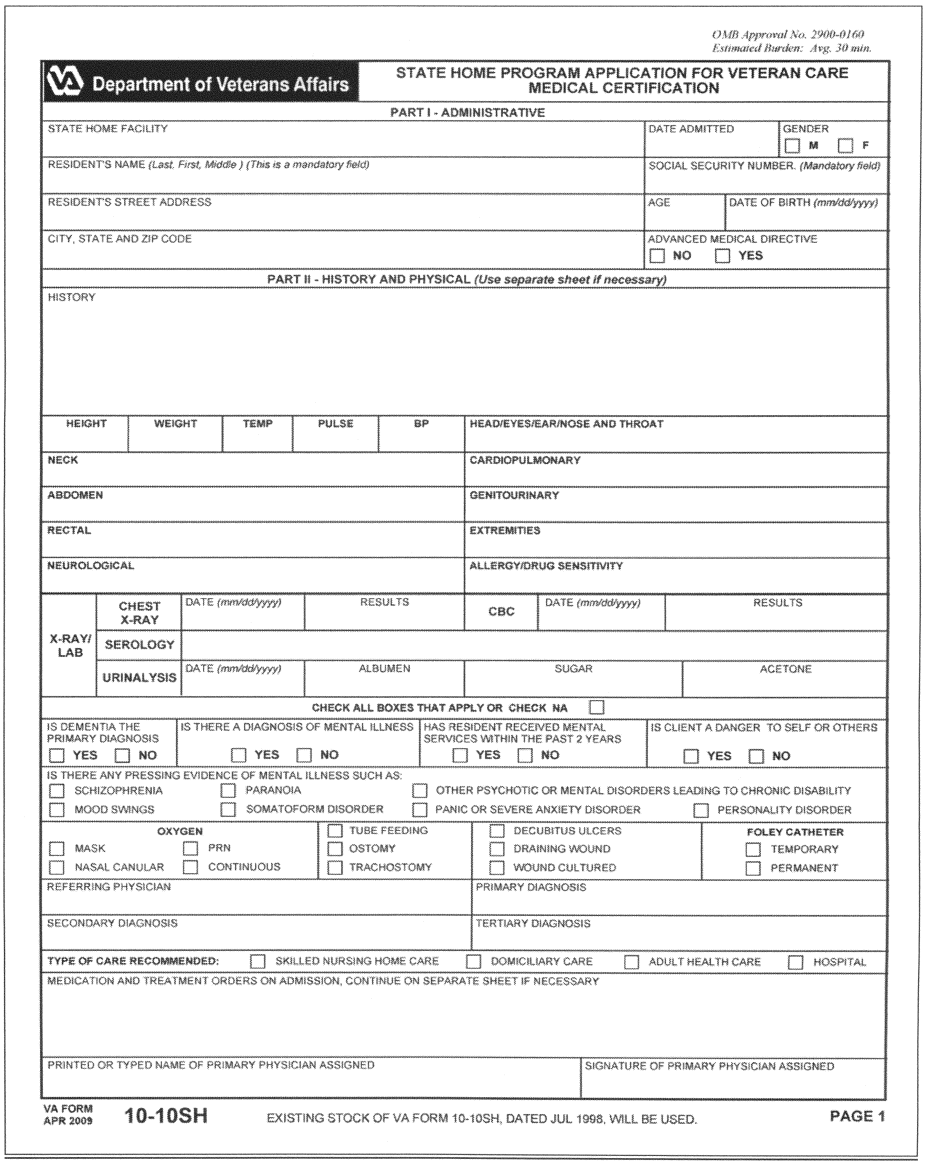
ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS ON WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT | DATE *(mm/dd/yyyy)*

VA FORM JUL 2008 **10-10EZR** PAGE 2

[65 FR 981, Jan. 6, 2000, as amended at 74 FR 19439, Apr. 29, 2009]

§ 58.13 VA Form 10–10SH—State Home Program Application for Veteran Care Medical Certification.



OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs — **STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER ☐ M ☐ F
RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	SOCIAL SECURITY NUMBER. *(Mandatory field)*	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH *(mm/dd/yyyy)*
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES	

PART II - HISTORY AND PHYSICAL ***(Use separate sheet if necessary)***

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT

NECK	CARDIOPULMONARY
ABDOMEN	GENITOURINARY
RECTAL	EXTREMITIES
NEUROLOGICAL	ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB	CHEST X-RAY	DATE *(mm/dd/yyyy)*	RESULTS	CBC	DATE *(mm/dd/yyyy)*	RESULTS
	SEROLOGY					
	URINALYSIS	DATE *(mm/dd/yyyy)*	ALBUMEN	SUGAR		ACETONE

CHECK ALL BOXES THAT APPLY OR CHECK NA ☐

IS DEMENTIA THE PRIMARY DIAGNOSIS ☐ YES ☐ NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS ☐ YES ☐ NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS ☐ YES ☐ NO	IS CLIENT A DANGER TO SELF OR OTHERS ☐ YES ☐ NO

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

OXYGEN							
☐ MASK	☐ PRN	☐ TUBE FEEDING	☐ DECUBITUS ULCERS	FOLEY CATHETER
☐ NASAL CANULAR	☐ CONTINUOUS	☐ OSTOMY	☐ DRAINING WOUND	☐ TEMPORARY
		☐ TRACHOSTOMY	☐ WOUND CULTURED	☐ PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT HEALTH CARE ☐ HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

VA FORM APR 2009 **10-10SH** EXISTING STOCK OF VA FORM 10-10SH, DATED JUL 1998, WILL BE USED. **PAGE 1**

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED

RESIDENT'S NAME *(Last, First, Middle)* | SOCIAL SECURITY NUMBER

EVALUATION (Select an appropriate number in each category)

COMMUNICATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totaly unable	**SPEECH**	☐ 1. Speak clearly with others of same language ☐ 2. Limited ability ☐ 3 Unable to speak clearly or not at all
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3 Nearly or totaly unable ☐ 4. Virtually/completely deaf	**SIGHT**	☐ 1. Good ☐ 2. Vision adequate - Unable to read/see details ☐ 3. Vision limited - Gross object differentiation ☐ 4. Blind
TRANSFER	☐ 1 No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human support ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
ENDURANCE	☐ 1. Tolerates distances (250 feet sustained activity) ☐ 2. Needs intermitten rest ☐ 3 Rarely tolerates short activites ☐ 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	☐ 1 Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Agreeable ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Well motivated
TOILETING	☐ 1. No assistance ☐ 2. Assistance to and from and transfer ☐ 3. Total assistance including personal hygiene, help with clothes ☐ A. Bathroom ☐ B. Bedside commode ☐ C. Bedpan	**BATHING**	☐ 1. No assistance ☐ 2. Supervision Only ☐ 3. Assistance ☐ 4. Is bathed ☐ A. Tub ☐ B. Shower ☐ C. Sponge bath
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3 Needs help to complete dressing ☐ 4 Has to be dressed	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance, needs tray set up only ☐ 3. Help feeding/encouraging ☐ 4. Is fed
BLADDER CONTROL	☐ 1 Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6 Catheter, indwelling	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Rarely incontinent ☐ 3. Occasional - once/week or less ☐ 4. Frequent - up to once a day ☐ 5. Total incontinence ☐ 6. Ostomy
SKIN CONDITION	☐ 1. Intact ☐ 2 Dry/Fragile ☐ 3. Irritations (Rash) ☐ 4 Open wound ☐ 5 Decubitus Number _____ Stage _____	**WHEEL CHAIR USE**	☐ 1. Independence ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable to use ☐ NA

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN | DATE

PHYSICAL THERAPY *(To be completed by Physical Therapist or Referring Physician)* ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY

SENSATION IMPAIRED	RESTRICT ACTIVITY	PRECAUTIONS	FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER *(Specify)*	

TREATMENT GOALS:
☐ ACTIVE ☐ COORDINATING ACTIVITIES ☐ FULL WEIGHT BEARING ☐ WHEELCHAIR INDEPENDENT
☐ STRETCHING ☐ ACTIVE ASSISTIVE ☐ NON-WEIGHT BEARING ☐ PROGRESS BED TO WHEELCHAIR ☐ COMPLETE AMBULATION
☐ PASSIVE ROM ☐ PROGRESSIVE RESISTIVE ☐ PARTIAL WEIGHT BEARING ☐ RECOVERY TO FUL FUNCTION

ADDITIONAL THERAPIES	SIGNATURE OF AND TITLE OF THERAPIST	DATE
☐ O.T. ☐ SPEECH ☐ DIETARY		

SOCIAL WORK ASSESSMENT *(To be completed by Social Worker)*

PRIOR LIVING ARRANGEMENTS	LONG RANGE PLAN	
ADJUSTMENT TO ILLNESS OR DISABILITY	SIGNATURE OF SOCIAL WORKER	DATE

VA AUTHORIZATION FOR PAYMENT

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT	LEVEL OF CARE RECOMMENDED
	☐ APPROVED ☐ DISAPPROVED	☐ NHC ☐ DOMICILIARY ☐ HOSPITAL ☐ ADHC

APPROVED FOR 70% SERVICE CONNECTED DISABILITY	APPROVED FOR ADMITANCE BECAUSE OF SERVICE CONNECTED ILLNESS (IF LESS THAN 70%) ILLNESS:
☐ YES ☐ NO	

SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

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PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742 and 1743. It is being collected to enable us to determine your eligibility for medical benefits in the State Home Program and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

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APR 2009 **10-10SH**

[65 FR 981, Jan. 6, 2000, as amended at 74 FR 19444, Apr. 29, 2009]

§ 58.14 VA Form 10–0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

_____ (hereinafter called the "Signatory")

(Name and location of State Veterans Home)

HEREBY AGREES THAT

It will comply with section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112) and all regulations adopted pursuant to such section, for instance, VA Regulations 7800 Series (38 CFR Section 18), to the end that no person in the United States shall, on the ground of handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statues administered by the VA; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate the agreement.

If any real property or structure thereon is provided or improved with the aid of the Federal financial assistance extended to the Signatory by the VA, this assurance shall obligate the Signatory, or in the case of transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by the VA.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under Section 1741 of Title 38 USC. Federal financial assistance is understood to include benefits paid directly to the Signatory, and/or benefits paid to a beneficiary contingent upon such beneficiary being enrolled in a program offered by the Signatory.

The Signatory recognizes and agrees that such Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance, and that the VA will withhold financial assistance, facilities, or other benefits to ensure fulfillment of this assurance of compliance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Signatory, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance.

SIGNATURE OF AUTHORIZED OFFICIAL	
TITLE	DATE
MAILING ADDRESS	

VA FORM SEP1998 (R) **10-0143A** **REPRODUCE LOCALLY** JetForm

§ 58.15 VA Form 10–0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 38 CFR 44, Subpart F. The regulations, published in the January 31, 1989, Federal Register (pages 4950-4952) require certification by grantees, prior to award, that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide suspension or debarment (see CFR Part 44, Section 44.100 through 44.420).

The grantee certifies that it will provide a drug-free workplace by:

(1) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(2) Establishing a drug-free awareness program to inform employees about

(a) The dangers of drug abuse in the workplace;
(b) The grantee's policy of maintaining a drug-free workplace;
(c) Any available drug counseling, rehabilitation, and employee assistance programs; and
(d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(3) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (1);

(4) Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will

(a) Abide by the terms of the statement; and
(b) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(5) Notifying the agency within ten days after receiving notice under subparagraph (4) (b) from an employee or otherwise receiving actual notice of such convictions;

(6) Taking one of the following actions, within 30 days of receiving notice under subparagraph (4) (b), with respect to any employee who is so convicted;

(a) Taking appropriate personnel action against such employee, up to and including termination; or
(b) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(7) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (1), (2), (3), (4), (5) and (6).

VA FORM SEP1998 (R) **10-0143** **REPRODUCE LOCALLY** JetForm

OMB Number: 2900-0188
Estimated Burden: 15 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

Places of Performance: The grantee shall insert in the space provided below the site(s) for performance of work done in connection with the specific grant (street address, city, county, state, zip code)

ORGANIZATION NAME	GRANT NUMBER OR NAME
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE

VA FORM SEP1998 (R) **10-0143** **REPRODUCE LOCALLY** JetForm

§ 58.16 VA Form 10–0144—Certification Regarding Lobbying.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

CERTIFICATION REGARDING LOBBYING

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is made in compliance with Section 319 of Public Law 101-121; and pursuant to the Interim Final guidance published as part VII of the December 20, 1989, Federal Register (Pages 57306-52332).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certified, to the best of their knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Forms-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31 U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE OF CERTIFYING OFFICIAL	DATE
NAME AND TITLE OF CERTIFYING OFFICIAL	PROJECT (FAI NUMBER)
NAME AND ADDRESS OF STATE AGENCY	

VA FORM SEP1999 (R) **10-0144** **REPRODUCE LOCALLY**

§ 58.17 VA Form 10–0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH EQUAL OPPORTUNITY LAWS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

_____(hereinafter called the"Signatory")
(Name of Organization, Institution, or Individual)

HEREBY AGREES THAT:

It will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), and all Federal regulations adopted to carry out such laws. This assurance is directed to the end that no person in the United States shall, on the ground of race, color, national origin (Title VI), handicap (Section 504), sex (Title IX, in education programs and activities only), or age (Age Discrimination Act) be excluded from participation in , be denied the benefits of, or be subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statutes administered by VA (Department of Veteran Affairs), the ED (Department of Education), or any other Federal agency. This assurance applies whether assistance is given directly to the recipient or indirectly through benefits paid to a student, trainee, or other beneficiary because of enrollment or participation in a program of the Signatory.

The Signatory HEREBY GIVES ASSURANCE that it will promptly take measures to effect this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Signatory or ED, this assurance-shall obligate the Signatory, or in the case of transfer of such property any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases, this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by VA, ED or any other Federal agency.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under sections 104 and 244(1) of Title 38, U.S.C. Also, sections 1713, 1720, 1720A, 1741-1743, 2408, 5902(a)(2), 8131-8137, 8151-8156 (formerly 613, 620, 620A, 641-643, 1008, 3402(a)(2), 5031-5037, 5051-5056 respectively) and 38 U.S.C. chapters 30, 31, 32, 35, 36, 82, and 10 U.S.C. chapter 106. Under the terms of an agreement between VA and ED, this assurance also includes Federal financial assistance given by ED through programs administered by that agency. Federal financial assistance is understood to include benefits paid directly to the Signatory and/or benefits paid to a beneficiary contingent upon the beneficiary's enrollment in a program or using services offered by the Signatory.

The Signatory agrees that Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance; that VA or ED will withhold financial assistance, facilities, or other benefits to assure compliance with the equal opportunity laws; and that the United States shall have the right to seek judicial enforcement of this assurance.

THIS ASSURANCE is binding on the Signatory, its successors, transferees, and assignees for the period during which assistance is provided. The Signatory assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to its students or trainees in connection with the Signatory's programs or services are not discriminating against those students or trainees in violation of the above statutes.

SIGNATURE OF AUTHORIZED OFFICIAL	DATE
NAME AND TITLE OF AUTHORIZED OFFICIAL	
MAILING ADDRESS OF AUTHORIZED OFFICIAL	

VA FORM APR 1999 (R) **10-0144A**

§ 58.18 VA Form 10–0460—Request for Prescription Drugs from an Eligible Veteran in a State Home.

OMB Approval No. 2900-XXXX
Estimated Burden: 30 minutes

Department of Veterans Affairs — **Request for Prescription Drugs from an Eligible Veteran in a State Home**

	VA Facility		Name and Address of State Home
To:		From:	

I am a veteran who was admitted to the _____ State Nursing Home.
I request that I be furnished with prescription drugs by the United States Department of Veterans Affairs as provided for in Title 38 of the Code of Federal Regulations, Section(s) 17.96 and/or 51.42.

I am eligible for this benefit by reason of being (check any of the following):

☐ (1) a veteran in receipt of increased VA compensation, or increased VA pension because I am permanently housebound or in need of regular aid and attendance.

☐ (2) a veteran in need of regular aid and attendance who was formerly in receipt of increased pension but whose pension has been discontinued solely by reason of excess income, and whose annual income does not exceed the maximum annual income limitation by more than $1,000.

☐ (3) a veteran who
(i) Has a singular or combined rating of 50 percent or 60 percent based on one or more service-connected disabilities or unemployability and is in need of such drugs and medicines; and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

☐ (4) a veteran who
(i) Has a singular or combined rating of less than 50 percent, based on one or more service-connected disabilities, and is in need of such drugs and medicines for a service-connected disability, and
(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

Signature of Veteran Applying for Benefit _____ **Date of Application** _____

Applicant Information

Veteran's Name (last, first, and middle initial):

Veteran's Social Security Number:	Date of Admission to the State Nursing Home:

Date that A&A or Housebound was awarded by VA:

(a copy of this award ☐ is or ☐ is not attached with this request)

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Diagnosis/Diagnoses for which the Applicant was Admitted to the State Nursing Home		
Diagnosis Code	**Diagnosis Name**	**Category of Eligibility from page 1** *(1, 2, 3 or 4)*
Name of Prescribing Physician:		**Telephone Number:**
I certify that the following medications are prescribed for _____ (Veteran's Name).		

_____
Signature of State Home Representative

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The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. We may not conduct or sponsor, and the respondent is not required to respond to, a collection unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, gather the necessary facts and fill out the form. This information is collected under the authority of Title 38 CFR Parts 51 and 58. It is being collected under the medical benefits in the State Homes Program and will be used for that purpose.

Privacy Act Information: It is being collected to enable us to determine your eligibility for medical benefits and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is mandatory. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute

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[74 FR 19447, Apr. 29, 2009]

PART 59—GRANTS TO STATES FOR CONSTRUCTION OR ACQUISITION OF STATE HOMES

Sec.