



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
 MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> YES	
HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMILIARY PER DIEM PAYMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN FPAPER FORM OR ELECTRONICALLY WITH THE 10-10SH			

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 <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATIFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
<input type="checkbox"/> PERSONALITY DISORDER		

OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS	<input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO

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

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

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN _____

DATE _____

PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician)

NEW REFERRAL CONTINUATION N/A

SENSATION IMPAIRED	RESTRICT ACTIVITY	PRECAUTIONS	FREQUENCY OF TREATMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	
TREATMENT GOALS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COORDINATING ACTIVITIES <input type="checkbox"/> FULL WEIGHT BEARING <input type="checkbox"/> WHEELCHAIR INDEPENDENT <input type="checkbox"/> STRETCHING <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> COMPLETE AMBULATION <input type="checkbox"/> PASSIVE ROM <input type="checkbox"/> PROGRESSIVE RESISTIVE <input type="checkbox"/> PARTIAL WEIGHT BEARING <input type="checkbox"/> RECOVERY TO FULL FUNCTION			

ADDITIONAL THERAPIES

O.T. SPEECH DIETARY

SIGNATURE OF AND TITLE OF THERAPIST OR REFERRING PHYSICIAN _____

DATE _____

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 _____

PART III VA AUTHORIZATION FOR PAYMENT	
<p style="text-align: center;">ADMINISTRATIVE REVIEW</p> <p>10-10EZ or 10-10EZR RECEIVED WITH 10-10SH: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ELECTRONIC VERSION</p> <p>Date Admitted to SVH: _____ Date Received by VA: _____</p> <p style="text-align: center;">NURSING HOME CARE</p> <p>SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70%: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>APPROVED PER DIEM RATE: <input type="checkbox"/> BASIC <input type="checkbox"/> PREVAILING RATE</p> <p style="text-align: center;">ADULT DAY HEALTH CARE</p> <p>ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;">DOMICILIARY CARE</p> <p>DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO, ADDITIONAL ELIGIBILITY REQUIREMENTS</p> <p>VA ADMINISTRATIVE SIGNATURE _____ DATE _____</p> <p>REMARKS:</p>	<p style="text-align: center;">CLINICAL REVIEW</p> <p>SERVICE CONNECTED CONDITION BEING ADMITTED FOR:</p> <p style="text-align: center;">NURSING HOME CARE</p> <p>IS VETERAN BEING ADMITTED DUE TO SC CONDITION: (IF LESS THAN 70%) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;">DOMICILIARY CARE</p> <p>DOES THE VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL EMPLOYMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;">ADULT DAY HEALTH CARE</p> <p>IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE: (38 U.S.C. 1720)(F)(1)(A)) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VETERAN APPROVED FOR ADULT DAY HEALTH CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>REMARKS:</p> <p>SIGNATURE OF VA PHYSICIAN/ANRP/PA _____ DATE _____</p>

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.

**INSTRUCTION SHEET
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL
CERTIFICATION
VA FORM 10-10SH**

This form should take an average of 30 minutes to complete

1. USE OF VA FORM 10-10SH, STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

As a condition for VA approved State Veterans Home (SVH) receive payment of per diem, the State home must submit to the VA medical center of jurisdiction for each veteran a completed VA Form 10-10SH, State Home Program Application for Care—Medical Certification and a 10-10EZ, Application for Health benefits or 101-10EZR, Health Benefits Renewal Form . This form must be submitted at the time of admission and with any request for a change in the level of care (domiciliary, nursing home care or adult day health care).

2. GENERAL INSTRUCTIONS

Part I (Administrative) and Part II (History and Physical) of the 10-10SH form must be completed in full by State Veterans Home designated staff. The completed VA Form 10-10SH must contain sufficient medical information to justify the level of care that is to be provided to the Veteran. Failure to submit or complete this form correctly may result in denial or delay of VA per diem payment.

Part III – VA Authorization for Payment is completed in full by VA Medical Center of Jurisdiction designated staff.

ADMINISTRATIVE REVIEW SECTION

- a. **10-10EZ or 10-10EZR Has Been Received with 10-10SH.** Check the appropriate if the forms were received with the 10-10SH or if the forms were completed electronically.
- b. **Date Admitted To SVH.** Enter the date the Veteran was physically admitted to the facility.
- c. **Date Received By VA.** Enter the date the complete admissions application was received by the VA.

Nursing Home Care

- d. **Service Connected Condition Rating Greater or Equal to 70%.** Check the appropriate answer YES or NO if the Veteran is 70% SC.
- e. **Does the Veteran Have a Rating of Total Disability Based on Individual employability?** Check the appropriate response, YES or NO.
- f. **Eligible for Per DIEM Payment Nursing Home Care.** Check the appropriate answer, YES or NO
- g. **Approved Per DIEM Rate.** Check either, Basic or the Prevailing rate.

Adult Day Health Care

- h. **Eligible for Per DIEM Payment for Adult Day Health Care.** Check the appropriate answer, YES or NO.
- i. **Service Connected Condition Rating.** Indicate the appropriate service connected rating if any for the Veteran being admitted to the SVH.
- j. **Approval For Per DIEM Payment.** Indicate the approval decision.
- k. **Approved Per Diem Rate.** Indicate the rate methodology, basic, higher or prevailing.

Domiciliary Care

- l. **Does Income Exceed Threshold For Aid & Attendance?** Indicate if the Veterans annual income exceeds the maximum amount of someone in receipt of Aid & Attendance for the following categories; Single Veteran, Veteran

with Spouse/Dependent, Two Veterans Married to Each Other, Surviving Spouse, or Surviving Spouse with One Dependent.

m. **VA Administrative Signature.** Sign and date when the administrative review was completed.

CLINICAL REVIEW SECTION

Is the Veteran being admitted for a service connected (SC) condition, it is important for the reviewing clinician to determine if the primary, secondary or tertiary diagnoses are service related and are the reasons the Veteran needs Nursing Home care as this determination affects per diem payments. If the reason for being admitted to the nursing home is a SC connected condition, identify the SC condition in the space provided.

Nursing Home Care

a. Is the Veteran Being Admitted Due to Service Connected Condition (if less than 70%). Check the appropriate answer, YES or NO.

b. Service Connected Condition Being Admitted For. Enter the service connected condition the Veteran is being admitted for.

c. Veteran Approved for Nursing Home Level of Care. Check the appropriate answer, YES or NO.

Domiciliary Care

c. Does the Veteran Have Means to Provide for Self or Provided for in the Community? Check the appropriate answer, YES or NO. When evaluating this question in addition to considering the Veterans annual income their wealth / assets also factor into the decision. If the Veteran has a lot of wealth /assets, the Veteran should be evaluated to determine if they have the means to provide adequately for self as it relates to finances.

d. Does Health and or Functional Deficits Render Veteran Unable of Pursuing Substantially Gainful Employment?

Check the appropriate answer, YES or NO.

If the Chief of Staff or designee makes the determination the Veteran is unable to pursue substantially gainful employment and the clinical provider reviewing the application determines the Veteran has health and functioning deficits that require the placement in the SVH and the Veteran is capable of performing the following daily living activities:

- (1) Perform without assistance daily adulations, such as brushing teeth, bathing, combing hair, and body eliminations.
- (2) Dress self, with minimum of assistance.
- (3) Proceed to and return from the dining hall without aid.
- (4) Feed self.
- (5) Secure medical attention on an ambulatory basis by use of personally propelled wheelchair.
- (6) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
- (7) Share in some measure, however slight, in the maintenance and operation of the facility.
- (8) Mark rational and competent decisions as to his or her desire to remain or leave the facility.

If all the above conditions are met, check "Yes" in the appropriate box. If these conditions are not met, check "No".

If any of the above questions are answered "No", per diem is not approved.

e. Veteran approved for Domiciliary Level of Care. Check the appropriate answer, YES or NO.

Adult Day Health Care

f. If Not Enrolled in ADHC, Will the Veteran Require Nursing Home Care? Check the appropriate answer, YES or NO.

d. Signature Of VA Physician/ARNP or PA and Date. Sign and date when the clinical review is completed.

Additional Information for completing the 10-10SH application.....

Answer all questions in the appropriate sections. If you need more space to answer a question, please attach a sheet of paper to the form containing the Veteran's name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.