



APPLICATION FOR FURNISHING LONG-TERM CARE SERVICES TO BENEFICIARIES OF VETERANS AFFAIRS

The Paperwork Reduction Act 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 complete this form will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and complete the form. This information is collected under the authority of Title 38, Part II, Sections 1710 and 1730. This information is used to determine your qualifications to provide Long-Term Care. Although this information is voluntary, failure to provide it will delay or prevent our approval of your agency. *Comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden may be sent to VHA Clearance Officer (19E1); Department of Veterans Affairs; 810 Vermont Ave. NW; Washington, DC 20420. DO NOT SEND YOUR APPLICATION TO THIS ADDRESS.*

1A. NAME/ADDRESS OF PROVIDER (Name, City, State, County & Zip)		1B. TELEPHONE NUMBER	3. IF THIS AGENCY IS PART OF A CHAIN, SPECIFY WHICH ONE	4. IS PROVIDER LICENCED OR APPROVED BY STATE IN WHICH LOCATED <input type="checkbox"/> YES <input type="checkbox"/> NO
		2. MEDICARE PROVIDER NO.		
5. PROVIDER IS CERTIFIED FOR PARTICIPATION IN MEDICARE/MEDICAID PROGRAM <input type="checkbox"/> YES <input type="checkbox"/> NO	6. TOTAL CAPACITY (Specify number)	7. NUMBER OF CLIENTS ON FILING DATE	8. NAME OF PHYSICIAN WHO ADVISED AGENCY ON PROFESSIONAL MATTERS	
9A. NAME OF DIRECTOR OF NURSING SERVICE		9B. IS DIRECTOR CURRENTLY LICENCED IN STATE WHERE NURSING HOME IS LOCATED <input type="checkbox"/> YES <input type="checkbox"/> NO		9C. REGISTRATION NO.
9D. IS THERE AN IN-SERVICE TRAINING PROGRAM FOR ALL NURSING PERSONNEL <input type="checkbox"/> YES <input type="checkbox"/> NO	10A. DATE FACILITY BUILT (N/A for home health)		10B. IS THERE AN AUTOMATIC FIRE SPRINKLER SYSTEM THROUGHOUT THE FACILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INITIAL SCHEDULE OF SERVICES (Case-mix/level of care)			12. AMOUNT (Price)	
(Attach additional sheets as necessary.)				

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13. FINAL SCHEDULE OF SERVICES (Case-mix/level of care)	14. AMOUNT (Price)
(Attach additional sheets as necessary.)	

15A. THE PROVIDER IS REQUESTED TO SIGN THIS DOCUMENT AND RETURN THE NUMBER OF COPIES SPECIFIED BELOW TO THE ISSUING OFFICE. PROVIDER AGREES TO FURNISH AND DELIVER ALL ITEMS SET FORTH OR OTHERWISE IDENTIFIED ABOVE AND ON ANY ADDITIONAL SHEET SUBJECT TO THE TERMS AND CONDITIONS SPECIFIED.	16. PROVIDER AGREEMENT NUMBER
15B. NUMBER OF COPIES REQUIRED BY ISSUING OFFICE	17. EFFECTIVE DATES OF AGREEMENT (Start date/end date)

18A. SIGNATURE OF PROVIDER		19A. SIGNATURE OF VA CENTER DIRECTOR OR DESIGNEE	
18B. NAME AND TITLE OF SIGNER (Type or Print)	18C. DATE SIGNED	19B. NAME OF VA CENTER DIRECTOR OR DESIGNEE (Type or Print)	19C. DATE SIGNED

20. COMMENTS