OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.
EXP: XX/XX/XXXX

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	

HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMILICIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ 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	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
☐ **YES** ☐ **NO** ☐ **N/A**	☐ **YES** ☐ **NO** ☐ **N/A**	☐ **YES** ☐ **NO** ☐ **N/A**	☐ **YES** ☐ **NO** ☐ **N/A**

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

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

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 activities ☐ 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	☐ 1. Alert ☐ 5. Agreeable ☐ 2. Confused ☐ 6. Disruptive ☐ 3. Disoriented ☐ 7. Apathetic ☐ 4. Comatose ☐ 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 ☐ A. Tub ☐ 2. Supervision Only ☐ B. Shower ☐ 3. Assistance ☐ C. Sponge bath ☐ 4. Is bathed
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 ☐ N/A

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 FULL FUNCTION

ADDITIONAL THERAPIES	SIGNATURE OF AND TITLE OF THERAPIST OR REFERRING PHYSICIAN	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

PART III VA AUTHORIZATION FOR PAYMENT

ADMINISTRATIVE REVIEW

10-10EZ or 10-10EZR RECEIVED WITH 10-10SH:
☐ **YES** ☐ **NO** ☐ **ELECTRONIC VERSION**

Date Admitted to SVH:

Date Received by VA:

NURSING HOME CARE

SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70%:
☐ YES ☐ NO

DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INIDIVIDUAL UNEMPLOYABILITY:
☐ YES ☐ NO

ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE:
☐ YES ☐ NO

APPROVED PER DIEM RATE:
☐ BASIC ☐ PREVAILING RATE

ADULT DAY HEALTH CARE

ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE:
☐ YES ☐ NO

DOMICILIARY CARE

DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCE:
☐ YES ☐ NO

ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE:
☐ YES ☐ NO, ADDITIONAL ELIGIBILITY REQUIREMENTS

VA ADMINISTRATIVE SIGNATURE | DATE

REMARKS:

CLINICAL REVIEW

SERVICE CONNECTED CONDITION BEING ADMITTED FOR:

NURSING HOME CARE

IS VETERAN BEING ADMITTED DUE TO SC CONDITION: (IF LESS THAN 70%)
☐ YES ☐ NO

VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE:
☐ YES ☐ NO

DOMICILIARY CARE

DOES THE VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY:
☐ YES ☐ NO

DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANIALLY GAINFUL EMPLOYMENT:
☐ YES ☐ NO

VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE:
☐ YES ☐ NO

ADULT DAY HEALTH CARE

IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE: (38 U.S.C. 1720)(F)(1)(A))
☐ YES ☐ NO

VETERAN APPROVED FOR ADULT DAY HEALTH CARE:
☐ YES ☐ NO

REMARKS:

SIGNATURE OF VA PHYSICIAN/ANRP/PA | DATE

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 SECTON
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.