OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Jan 31, 2016

Department of Veterans Affairs

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

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED

3. STATE HOME FACILITY ADDRESS (street, city, state and zip code)

4. RESIDENT'S NAME (Last, First, Middle) (This is a mandatory Field)

5. SOCIAL SECURITY NUMBER (Mandatory Field)	6. GENDER ☐ M ☐ F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)

9. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

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

10. HISTORY

11. HEIGHT	12. WEIGHT	13. TEMP	14. PULSE	15. BP	16. HEAD/EYES/EARS/NOSE AND THROAT

17. NECK	18. CARDIOPULMONARY

19. ABDOMEN	20. GENITOURINARY

21. RECTAL	22. EXTREMITIES

23. NEUROLOGICAL	24. ALLERGY/DRUG SENSITIVITY

25. X-RAY/ LAB						
	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	CBC	DATE (MM/DD/YYYY)	RESULT
	SEROLOGY					
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CHECK N/A

26. IS DEMENTIA THE PRIMARY DIAGNOSIS ☐ YES ☐ NO ☐ N/A	27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS ☐ YES ☐ NO ☐ N/A	28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS ☐ YES ☐ NO ☐ N/A	29. IS CLIENT A DANGER TO SELF OR OTHERS ☐ YES ☐ NO ☐ N/A

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

31. OXYGEN	32. FEEDING	33. WOUND	34. FOLEY CATHETER
☐ MASK ☐ PRN ☐ N/A	☐ TUBE FEEDING ☐ N/A	☐ DECUBITUS ULCERS ☐ N/A	☐ TEMPORARY ☐ N/A
☐ NASAL CANULAR ☐ CONTINUIOUS	☐ OSTOMY ☐ TRACHOSTOMY	☐ DRAINING WOUND ☐ WOUND CULTURED	☐ PERMANENT

35. REFERRING PHYSICIAN	36. PRIMARY DIAGNOSIS

37. SECONDARY DIAGNOSIS	38. TERTIARY DIAGNOSIS

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

40. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

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

42. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	43. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

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PART III - EVALUATION (Select an appropriate number in each category)

44. RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	45. SOCIAL SECURITY NUMBER (Mandatory Field)

COMMUNICATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally 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 totally 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 assistance 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 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 ☐ N/A

46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	47. DATE:

PHYSICAL THERAPY ***(To be completed by Physical Therapist or Referring Physician)*** | 48. Check if ☐ NEW REFERRAL ☐ CONTINUATION OR THERAPY

49. SENSATION IMPAIRED	50. RESTRICT ACTIVITY	51. PRECAUTIONS	52. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER (Type other, specify)	

53. 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

54. ADDITIONAL THERAPIES	55. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN	56. DATE:
☐ O.T. ☐ SPEECH ☐ DIETARY		

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

57. PRIOR LIVING ARRANGEMENTS	58. LONG RANGE PLAN

59. ADJUSTMENT TO ILLNESS OR DISABILITY	60. PRINT NAME OF SOCIAL WORKER	61. SIGNATURE OF SOCIAL WORKER	62. DATE:

63. REMARKS:

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Department of Veterans Affairs

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

PART V VA AUTHORIZATION FOR PAYMENT

ADMINISTRATIVE REVIEW

64. 10-10EZ or 10-10EZR RECEIVED WITH 10-10SH
☐ YES ☐ NO ☐ ELECTRONIC VERSION

65. DATE ADMITTED TO SVH

66. DATE RECEIVED BY VA

NURSING HOME CARE

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

68. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY:
☐ YES ☐ NO

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

70. APPROVED PER DIEM RATE:
☐ BASIC ☐ PREVAILING

ADULT DAY HEALTH CARE

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

DOMICILIARY CARE

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

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

74. REMARKS:

75. SIGNATURE OF VA ADMINISTRATIVE REVIEWER

76. DATE:

CLINICAL REVIEW

77. SERVICE CONNECTED CONDITION BEING ADMITTED FOR:

NURSING HOME CARE

78. IS VETERAN BEING ADMITTED DUE TO SC CONDITION:
☐ YES ☐ NO

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

DOMICILIARY CARE

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

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

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

ADULT DAY HEALTH CARE

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

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

85. REMARKS:

86. SIGNATURE OF VA PHYSICIAN/ANRP/PA

87. DATE:

PAPERWORK REDUCTION ACT OF 1995 AND PRIVACY ACT STATEMENT

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 20 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 maybe entitled. This information is collected under the authority Of Title 38 CFR Parts 51 and 52. 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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VA FORM 10-10SH
INSTRUCTIONS FOR
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 10-10EZR, 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).

PART I-ADMINISTRATIVE

This section must be completed in full by State Veterans Home designated staff.

1. STATE HOME FACILITY-Enter the name of the facility
2. DATE ADMITTED-Select the date admitted using the calendar or enter the date as MM/DD/YYY
3. STATE HOME FACILITY ADDRESS- Enter complete address
4. RESIDENT'S NAME-Enter the full name of the person in which this application applies
5. SOCIAL SECURITY NUMBER-Enter the full social security number of the applicant
6. GENDER-Check the appropriate box
7. AGE-Age of applicant
8. DATE OF BIRTH-Enter the date of birth in the format MM/DD/YYYY
9. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMILICIARY PER DIEM PAYMENTS-check yes or no

PART II-HISTORY AND PHYSICAL

This section 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.

10: HISTORY-Enter the patient background and history
11. HEIGHT-Enter the applicant's height
12. WEIGHT-Enter the applicant's weight
13. TEMP-Enter the applicant's temperature
14. PULSE-Enter the applicant's pulse rate
15. BP-Enter the applicant's blood pressure
16. HEAD/EYES/EARS/NOSE AND THROAT-Enter any problems with the head, eyes, ears, nose and throat
17. NECK-Enter any problems with the neck
18. CARDIOPULMONARY-Enter any problems with the heart
19. ABDOMEN-Enter any problems with the abdomen
20. GENITOURINARY-Enter any problems with the genitourinary
21. RECTAL-Enter any problems with the rectum
22. EXTREMITIES-Enter any problems with the extremities
23. NEUROLOGICAL-Enter any problems neurologically
24. ALLERGY/DRUG SENSITIVITY-Enter any allergies or sensitivities
25. X-RAY/LAB-Date of chest x-ray, results; CBC date, result; serology; urinalysis date, albumen, sugar, acetone
26. IS DEMENTIA THE PRIMARY DIAGNOSIS- Check yes, no or N/A (not applicable)
27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS-Check yes, no or N/A (not applicable)
28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WHITHIN THE PAST 2 YEARS-Check yes, no or N/A (not applicable)
29. IS CLIENT A DANGER TO SELF OR OTHERS-Check yes, no or N/A (not applicable)
30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS- Check all that apply or check N/A
31. OXYGEN-Check all that apply or check N/A
32. FEEDING-Check all that apply or check N/A
33. WOUND-Check all that apply or check N/A
34. FOLEY CATHETER-Check all that apply or check N/A
35. REFERRING PHYSICIAN- Enter the name of the referring physician
36. PRIMARY DIAGNOSIS-Enter the primary diagnosis
37. SECONDARY DIAGNOSIS-Enter the secondary diagnosis
38. TERTIARY DIAGNOSIS-Enter the tertiary diagnosis
39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION- Enter yes or no
40. TYPE OF CARE RECOMMENDED-Choose the appropriate care
41. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY- Enter all medications and treatment orders on the applicant.
42. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED-Enter the name of the physician
43. SIGNATURE OF PRIMARY PHYSICIAN-Enter signature

PART III - EVALUATION

44. RESIDENT'S NAME-Enter the full name of the person in which this application applies
45. SOCIAL SECURITY NUMBER-Enter the full social security number of the applicant
46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN-Enter signature
47. DATE- Enter date signed by registered nurse or referring physician

PHYSICAL THERAPY

48. Check the box if new of continued therapy
49. SENSATION IMPAIRED-Check yes or no
50. RESTRICT ACTIVITY- Check yes or no
51. PRECAUTIONS-Check if there is a cardiac or other (for other type over the text in the box)
52. FREQUENCY OF TREATMENT-Enter often the applicant receives physical therapy
53. TREATMENT GOALS-Check all that apply
54. ADDITIONAL THERAPIES-Check all that apply
55. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN- Enter the signature
56. DATE-Enter the date the Therapist or Physician signed (format MM/DD/YYYY)

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

57. PRIOR LIVING ARRANGEMENTS
58. LONG RANGE PLAN
59. ADJUSTMENT TO ILLNESS OR DISABILITY
60. PRINT NAME OF SOCIAL WORKER
61. SIGNTURE OF SOCIAL WORKER
62. DATE
63. REMARKS

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VA FORM 10-10SH
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PART V - VA AUTHORIZATION FOR PAYMENT
Completed in full by VA Medical Center of Jurisdiction designated staff

ADMINISTRATIVE REVIEW SECTION

64. 10-10EZ OR 10-10EZR RECIEVED WITH 10-10SH-Check the appropriate if the forms were received with the 10-10SH or if the forms were completed electronically.
65. DATE ADMITTED TO SVH-Enter the date the Veteran was physically admitted to the State Veteran's Home
66. DATE RECEIVED BY VA-Enter the date the complete admission application was received by the VA.

NURSING HOME CARE

67. SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70%-Check YES or NO if the Veteran is 70% SC.
68. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY?-Check YES or NO.
69. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE-Check YES or NO
70. APPROVED PER DIEM RATE-Check either, Basic or the Prevailing rate.

ADULT DAY HEALTH CARE

71. ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE-Check YES or NO.

DOMICILIARY CARE

72. 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.
73. ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE- Enter YES if eligible and NO is there are additional eligibility requirements
74. REMARKS- Enter any remarks regarding this section.
75. SIGNATURE OF VA ADMINISTRATIVE REVIEWER-Enter signature
76. DATE-Date VA Administrator signed

CLINICAL REVIEW SECTON

77. SERVICE CONNECTED CONDITION BEING ADMITTED FOR-If necessary, review VA databases such as VISTA, HINQ, VIS or CPRS for Veteran's service-connection condition/rating. Enter the service connected condition the Veteran is being admitted for.

NURSING HOME CARE

78. IS VETERAN BEING ADMITTED DUE TO SERVICE CONNECTED CONDITION. Check YES or NO.
79. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE - Check YES or NO.

DOMICILIARY CARE

80. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY- Check YES or NO.
81. DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL EMPLOYMENT- Check YES or NO. If Veteran is unable to pursue substantially gainful employment and the clinical provider (reviewer) determines the Veteran has health and functioning deficits that require domiciliary care 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 or 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) Make 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.
82. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE-Check yes or no.

ADULT DAY HEALTH CARE

83. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE: (38 U.S.C. 1720, (F)(1)(A))-Check YES or NO.
84. VETERAN APPROVED FOR ADULT DAY HEALTH CARE:
85. REMARKS-Enter any remarks regarding this section.
86. SIGNATURE OF VA PHYSICIAN/ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) OR PHYSICIAN ASSISTANT (PA)- Enter Signature
87. DATE-Date VA Physician/ARNP or PA signed

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

Answer all questions in the appropriate sections. If additional space is needed, write “Continuation of the Item” in that section and attach a sheet of paper containing the Veteran's Name, Social Security Number and the section and question number from the form needing the additional information.