



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 <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <b>10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH</b>			

**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 <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	29. IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
30. IS THERE ANY PRESSING EVIDENCE OR 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"/> N/A <input type="checkbox"/> MOOD SWINGS <input type="checkbox"/> SOMATOFORM DISORDER <input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER <input type="checkbox"/> PERSONALITY DISORDER			
31. OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> N/A <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS	32. FEEDING <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> N/A <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	33. WOUND <input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> N/A <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	34. FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> N/A <input type="checkbox"/> PERMANENT
35. REFERRING PHYSICIAN		36. PRIMARY DIAGNOSIS	
37. SECONDARY DIAGNOSIS		38. TERTIARY DIAGNOSIS	
39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
40. TYPE OF CARE RECOMMENDED: <input type="checkbox"/> SKILLED NURSING HOME CARE <input type="checkbox"/> DOMICILIARY CARE <input type="checkbox"/> 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	



**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)		
<b>COMMUNICATION</b>	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	<b>SPEECH</b>	<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	
<b>HEARING</b>	<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	<b>SIGHT</b>	<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	
<b>TRANSFER</b>	<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	<b>AMBULATION</b>	<input type="checkbox"/> 1. Independence w/wo assistance 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	
<b>ENDURANCE</b>	<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	<b>MENTAL AND BEHAVIOR STATUS</b>	<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	
<b>TOILETING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from 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	<b>BATHING</b>	<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
<b>DRESSING</b>	<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	<b>FEEDING</b>	<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	
<b>BLADDER CONTROL</b>	<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	<b>BOWEL CONTROL</b>	<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	
<b>SKIN CONDITION</b>	<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:	<b>WHEEL CHAIR USE</b>	<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"/> N/A

46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	47. DATE:
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<b>PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician)</b>		48. Check if <input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> CONTINUATION OR THERAPY	
49. SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	50. RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	51. PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER	52. FREQUENCY OF TREATMENT
53. 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			
54. ADDITIONAL THERAPIES <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY		56. DATE:	
55. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN			

**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:			



**Department of Veterans Affairs**

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

**PART V VA AUTHORIZATION FOR PAYMENT**

<b>ADMINISTRATIVE REVIEW</b>		<b>CLINICAL REVIEW</b>	
64. 10-10EZ or 10-10EZR RECEIVED WITH 10-10SH <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ELECTRONIC VERSION		77. SERVICE CONNECTED CONDITION BEING ADMITTED FOR:	
65. DATE ADMITTED TO SVH	66. DATE RECEIVED BY VA	<b>NURSING HOME CARE</b>	
<b>NURSING HOME CARE</b>		78. IS VETERAN BEING ADMITTED DUE TO SC CONDITION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
67. SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70%: <input type="checkbox"/> YES <input type="checkbox"/> NO		79. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
68. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY: <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>DOMICILIARY CARE</b>	
69. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		80. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY: <input type="checkbox"/> YES <input type="checkbox"/> NO	
70. APPROVED PER DIEM RATE: <input type="checkbox"/> BASIC <input type="checkbox"/> PREVAILING		81. DOES HEALTH AND /OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL EMPLOYMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>ADULT DAY HEALTH CARE</b>		82. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
71. ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>ADULT DAY HEALTH CARE</b>	
<b>DOMICILIARY CARE</b>		83. 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	
72. DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO		84. VETERAN APPROVED FOR ADULT DAY HEALTH CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	
73. ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO, ADDITIONAL ELIGIBILITY REQUIREMENTS		85. REMARKS:	
74. REMARKS:		86. SIGNATURE OF VA PHYSICIAN/ANRP/PA	
75. SIGNATURE OF VA ADMINISTRATIVE REVIEWER		87. DATE:	
76. DATE:		88. SIGNATURE OF VA ADMINISTRATIVE REVIEWER	

**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.



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<br>2. DATE ADMITTED-Select the date admitted using the calendar or enter the date as MM/DD/YYYY<br>3. STATE HOME FACILITY ADDRESS- Enter complete address<br>4. RESIDENT'S NAME-Enter the full name of the person in which this application applies<br>5. SOCIAL SECURITY NUMBER-Enter the full social security number of the applicant | 6. GENDER-Check the appropriate box<br>7. AGE-Age of applicant<br>8. DATE OF BIRTH-Enter the date of birth in the format MM/DD/YYYY<br>9. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMILIARIY 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<br>11. HEIGHT-Enter the applicant's height<br>12. WEIGHT-Enter the applicant's weight<br>13. TEMP-Enter the applicant's temperature<br>14. PULSE-Enter the applicant's pulse rate<br>15. BP-Enter the applicant's blood pressure<br>16. HEAD/EYES/EARS/NOSE AND THROAT-Enter any problems with the head, eyes, ears, nose and throat<br>17. NECK-Enter any problems with the neck<br>18. CARDIOPULMONARY-Enter any problems with the heart<br>19. ABDOMEN-Enter any problems with the abdomen<br>20. GENITOURINARY-Enter any problems with the genitourinary<br>21. RECTAL-Enter any problems with the rectum<br>22. EXTREMITIES-Enter any problems with the extremities<br>23. NEUROLOGICAL-Enter any problems neurologically<br>24. ALLERGY/DRUG SENSITIVITY-Enter any allergies or sensitivities<br>25. X-RAY/LAB-Date of chest x-ray, results; CBC date, result; serology; urinalysis date, albumen, sugar, acetone<br>26. IS DEMENTIA THE PRIMARY DIAGNOSIS- Check yes, no or N/A (not applicable)<br>27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS-Check yes, no or N/A (not applicable) | 28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS-Check yes, no or N/A (not applicable)<br>29. IS CLIENT A DANGER TO SELF OR OTHERS-Check yes, no or N/A (not applicable)<br>30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS- Check all that apply or check N/A<br>31. OXYGEN-Check all that apply or check N/A<br>32. FEEDING-Check all that apply or check N/A<br>33. WOUND-Check all that apply or check N/A<br>34. FOLEY CATHETER-Check all that apply or check N/A<br>35. REFERRING PHYSICIAN- Enter the name of the referring physician<br>36. PRIMARY DIAGNOSIS-Enter the primary diagnosis<br>37. SECONDARY DIAGNOSIS-Enter the secondary diagnosis<br>38. TERTIARY DIAGNOSIS-Enter the tertiary diagnosis<br>39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION- Enter yes or no<br>40. TYPE OF CARE RECOMMENDED-Choose the appropriate care<br>41. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY- Enter all medications and treatment orders on the applicant.<br>42. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED-Enter the name of the physician<br>43. SIGNATURE OF PRIMARY PHYSICIAN-Enter signature |
|--|--|

**PART III - EVALUATION**

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|--|--|
| 44. RESIDENT'S NAME-Enter the full name of the person in which this application applies<br>45. SOCIAL SECURITY NUMBER-Enter the full social security number of the applicant<br>46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN-Enter signature<br>47. DATE- Enter date signed by registered nurse or referring physician<br><br><u>PHYSICAL THERAPY</u><br>48. Check the box if new of continued therapy<br>49. SENSATION IMPAIRED-Check yes or no | 50. RESTRICT ACTIVITY- Check yes or no<br>51. PRECAUTIONS-Check if there is a cardiac or other (for other type over the text in the box)<br>52. FREQUENCY OF TREATMENT-Enter often the applicant receives physical therapy<br>53. TREATMENT GOALS-Check all that apply<br>54. ADDITIONAL THERAPIES-Check all that apply<br>55. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN- Enter the signature<br>56. DATE-Enter the date the Therapist or Physician signed (format MM/DD/YYYY) |
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**PART IV SOCIAL WORK ASSESSMENT (To be completed by Social Worker)**

- |   |  |
|---|--|
| 57. PRIOR LIVING ARRANGEMENTS<br>58. LONG RANGE PLAN<br>59. ADJUSTMENT TO ILLNESS OR DISABILITY | 60. PRINT NAME OF SOCIAL WORKER<br>61. SIGNATURE OF SOCIAL WORKER<br>62. DATE<br>63. REMARKS |
|---|--|



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

**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.
- 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.