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| | | | | | | PART I - | | NISTRA | TIVE | | | | | |
|--|--|--------------------------------------|-------------------|----------------|------------------------------------|------------|--------|--|-----------------------|---------------|------------|---------|----------------|----------|
| 4. RESIDENT'S NAME (Last, First, Middle) (This is a mandatory Field) 5. SOCIAL SECURITY NUMBER (Mandatory Field) 6. GENDER 7. AGE 8. DATE OF BIRTH (MMIDD/YYYY) 8. JAST HE VETERAN PROVIDED FINANCIAL DISCOURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILARY PER DIEM PAYNEN 9. HAS THE VETERAN PROVIDED FINANCIAL DISCOURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILARY PER DIEM PAYNEN 9. HAS THE VETERAN PROVIDED FINANCIAL DISCOURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILARY PER DIEM PAYNEN 9. HAS THE VETERAN PROVIDED FINANCIAL DISCOURE FOR PURPOSES 9. HAS THE VETERAN PROVIDED FINANCIAL DISCOURE FOR PURPOSES 9. HISTORY 10. HISTORY 11. HEIGHT 12. WEIGHT 13. TEMP 14. PULSE 14. HISTORY 15. ABDOMEN 20. GENITOURINARY 21. RECTAL 22. EXTREMITIES 23. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 24. ALLERGY/DRUG SENSITIVITY RESULT 25. XRAY SEROLOGY 28. IS DEMENTITA THE FRIMARY ZI STHERE A DAGNOSIS OF 29. IS CLIENT A DANCES MENTAL LINESS 20. IS THERE AND LINKESS MENTAL LINESS 21. THE CHANNERY ZI STHERE A DAGNOSIS OF 24. ALLERGY/DRUG SENSITIVITY | 1. STATE HOME FACILITY | | | | | | | | | | | | 2. DATE AI | OMITTE |
| 5. SOCIAL SECURITY NUMBER (Mandatory Field) 6. GENDER 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 PAYMEN PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary) 10. HISTORY PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary) 10. HISTORY 13. TEMP 14. PULSE 15. BP 16. HEAD/EYES/EARS/NOSE AND THROAT 11. HEIGHT 12. WEIGHT 13. TEMP 14. PULSE 15. BP 16. HEAD/EYES/EARS/NOSE AND THROAT 13. ABDOMEN 20. GENITOURINARY 21. RECTAL 22. EXTREMITIES 23. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 24. ALLERGY/DRUG SENSITIVITY SEGOLOGY 25. XRAY SEGOLOGY 22. EXTREMITIES 26. IS DEMENTIA THE PRIMARY 22. EXTREMITIES 23. IS CLENT A DANGE MINING WOUND/YYYY) 25. SCRUG GY 27. IS THERE A DAGNOSIS OF 28. HAS THE RESIDENT RECEIVED 20. OR OTHERS 20. IS CLENT A DANGE MINING WOUND 26. IS DEMENTIA THE PRIMARY 22. IS CLENT A DANGE MINING WOUND 20. IS CLENT A DANGE 26. IS DEMENTIA THE PRIMARY 22. IS CLENT A DANGE OR OTHERS 27. IS THERE A DAGNOSIS OF 28. HAS THE RESIDENT RECEVED 20. OR OTHERS OR OTHERS | 3. STATE H | OME FACILITY | ADDRESS (st | reet, city, st | ate and zip o | ode) | | | | | | | | |
| a boold of the classify is boy in the classify is boy in the classify in the cl | . RESIDEN | T'S NAME (La | st, First, Middle |) (This is a n | mandatory Fi | eld) | | | | | | | | |
| M F M F M F M 10-002-01 closule FOR EVURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMEN PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary) 10. HISTORY 11. HEIGHT 12. WEIGHT 12. WEIGHT 13. TEMP 14. PULSE 15. BP 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 15. SP DATE (MM/DD/YYYY) RESULT CBC CHEST DATE (MM/DD/YYYY) RESULT CBC VES NO | | | MBER (Mandat | ory Field) | 6. GENDE | ER | | | 7 AGE | | | BIRTH (| | |
| VES NO NA 10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH 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 7. NECK 18. CARDIOPULMONARY 19. ABDOMEN 20. GENITOURINARY 11. RECTAL 22. EXTREMITIES 33. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY CHEEST DATE (MM/DD/YYYY) SEROLOGY URINALY SIS DATE (MM/DD/YYYY) ALBUMEN SUGAR ACETONE SEROLOGY URINAL SERVICES WITHIN THE PRIMARY 27. IS THERE A DIAGONSIS OF 28. MAS THE RESIDENT RECEIVED SEROLOGY URINAL SERVICES WITHIN THE PRIMARY 27. IS THERE A DIAGONSIS OF 10. DIAL 21. METAL LILNESS 20. IS CLIENT A DANGER CHECK ALL BOXES THAT APPLY OR CHECK N/A 6. IS DEMENTIA THE PRIMARY <td colspan="7"></td> <td>DETER</td> <td colspan="3"></td> <td></td> <td></td> <td>2</td> | | | | | | | | DETER | | | | | | 2 |
| 0. HISTORY 11. HEIGHT 12. WEIGHT 13. TEMP 14. PULSE 15. BP 16. HEAD/EYES/EARS/NOSE AND THROAT 17. NECK 18. CARDIOPULMONARY 18. CARDIOPULMONARY 19. ABDOMEN 20. GENITOURINARY 11. RECTAL 22. EXTREMITIES 12. RECTAL 22. EXTREMITIES 13. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 15. X.RAY DATE (MMDD/YYYY) RESULT CBC 16. IS DEMENTIA THE PRIMARY JACK ALLENSS 27. IS THEREA ADIAGNOSIS OF LEVEND METAL SERVICES WITHIN THE PAST2 16. IS DEMENTIA THE PRIMARY JACK ALLENSSS 27. IS THEREA ADIAGNOSIS OF LEVEND METAL SERVICES WITHIN THE PAST2 10. IS THEREA APPRESSING CUBACK OR METAL LILENESS INA 11. OXYOGEN 27. IS THEREA ADIAGNOSIS OF LEVEND MARKAN CONCINCIDABILITY 10. STHEREA ANY PRESSING CUBACK OR METAL LILLENESS SUCH AS 15. GOLORAT CONSIDENTIAL LILLENESS UNTHAN THE PAST2 10. IS THEREA ANY PRESSING CUBACK OR METAL LILLENESS SUCH AS 13. WOUND 11. OXYOGEN 32. FEEDING 11. OXYOGEN 32. FEEDING 13. SUCUND IS SOMATOFORM DISORDER 13. KOUND ISOTORY 14. REFERRING PHYSICIAN 33. WOUND 35. FE | | | | 10EZ or 10- | 10EZR IS RI | EQUIRED TO | BE SI | UBMITT | ED EITHEI | R IN PAPER I | FORM OR EI | | | |
| 1. HEIGHT 12. WEIGHT 13. TEMP 14. PULSE 15. BP 16. HEAD/EYES/EARS/NOSE AND THROAT 7. NECK 18. CARDIOPULMONARY 9. ABDOMEN 20. GENITOURINARY 11. RECTAL 22. EXTREMITIES 3. NEUROLOGICAL 24. ALLERGYIDRUG SENSITIVITY 5. X-RAYI DATE (MM/DD/YYYY) RESULT CBC DATE (MM/DD/YYYY) RESULT 5. X-RAYI URINALYSIS DATE (MM/DD/YYYY) RESULT CBC CBC CD CTC NA 6. IS DEMENTIA THE PRIMARY Z7. IS THERE A DIAGNOSIS OF 28. HAS THE RESIDENT RECEIVED OR OTHERS CD CHECK IL BOXES THAT APPLY OR CHECK INA CBC CD CHECK IL BOXES THAT APPLY OR CHECK INA CBC CHERS INTHIN THE PAST 2 OR OTHERS CD CHECK IL BOXES SUTHA IL ILNESS CBC IL BOXES WITHIN THE PAST 2 OR OTHERS | | V | | PART | II - HISTOR | Y AND PHYS | SICAL | (Use se | eparate she | et if necessa | ary) | | | |
| 17. NECK 18. CARDIOPULMONARY 19. ABDOMEN 20. GENITOURINARY 19. ABDOMEN 20. GENITOURINARY 11. RECTAL 22. EXTREMITIES 23. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 5. X-RAY SEROLOGY URINALYSIS DATE (MM/DD/YYYY) RESULT CBC 5. X-RAY SEROLOGY URINALYSIS DATE (MM/DD/YYYY) ALBUMEN SUGAR ACETONE CHECK ALL BOXES THAT APPLY OR CHECK N/A 6. IS DEMENTIA THE PRIMARY 27. IS THERE A DIAGNOSIS OF MENTAL SERVICES WITHIN THE PAST 2 0. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLINESS CHECK ALL BOXES THAT APPLY OR CHECK N/A 6. IS DEMENTIA THE PRIMARY 27. IS THERE A DIAGNOSIS OF MENTAL SERVICES WITHIN THE PAST 2 29. IS CLIENT A DANGEF 0. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLINESS MENTAL SERVICES WITHIN THE PAST 2 29. IS CLIENT A DANGEF SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDER LEADING TO CHRONIC DISABILITY N MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVER ANXIETY DISORDER PERSONALITY DISORDER MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVER ANXIETY DISORDER PERSONALITY DISORDER | IU. HISTOR | T | | | | | | | | | | | | |
| | 1. HEIGHT | 12. WEIGHT 13. TEMP 14. PULSE 15. BP | | | 16. HEAD/EYES/EARS/NOSE AND THROAT | | | | | | | | | |
| 21. RECTAL 22. EXTREMITIES 23. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 25. X-RAY DATE (MM/DD/YYYY) 26. IS DEMENTIA THE PRIMARY DATE (MM/DD/YYYY) 27. IS THERE ADJAGNOSIS OF MENTAL ILLINESS DATE (MM/DD/YYYY) 28. IS DEMENTIA THE PRIMARY 27. IS THERE ADJAGNOSIS OF MENTAL ILLINESS NO 29. IS CLIENT A DANGER OR OTHERS 20. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLINESS SUCH AS: SIGCOND IN/A 29. IS CLIENT A DANGER OR OTHERS 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLINESS SUCH AS: SIGCUENT DISORDER 31. GOLZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER 11. OXYGEN 32. FEEDING 33. WOUND 34. FOLEY OF 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 34. FOLEY OF 36. REFERRING PHYSICIAN 38. TERTIARY DIAGNOSIS 37. SECONDARY DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 36. REFERRING PHYSICIAN 38. TERTIARY DIAGNOSIS 37. SECONDARY DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO | 17. NECK | | | | | | | 18. CARDIOPULMONARY | | | | | | |
| 23. NEUROLOGICAL 24. ALLERGY/DRUG SENSITIVITY 25. X-RAY 26. X-RAY 27. IS THERE A DIATE (MM/DD/YYYY) 27. IS THERE A DIAGNOSIS 28. HAS THE RESIDENT RECEIVED CHECK ALL BOXES THAT APPLY OR CHECK N/A 29. IS CLIENT A DANGE CHECK ALL BOXES THAT APPLY OR CHECK N/A 29. IS CLIENT A DANGEF CHECK ALL BOXES THAT APPLY OR CHECK N/A 29. IS CLIENT A DANGEF CHECK ALL BOXES THAT APPLY OR CHECK N/A 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS THERE ANY PRESING PRIMARY 20. IS THERE ANY PRESING EVIDENCE OR MENTAL INCESS 20. IS CONTINUOUS 20. SOMATOFORM DISORDER 20. IS THERE ANY PRESING PRIMARY 20. IS THERE ANY PRIMARY 20. IS THERE | 19. ABDOMEN | | | | | | | 20. GENITOURINARY | | | | | | |
| CHEST X-RAY DATE (MM/DD/YYYY) RESULT CBC DATE (MM/DD/YYYY) RESULT 25. X-RAY/ LAB SEROLOGY | 21. RECTAL | | | | | | | 22. EXTREMITIES | | | | | | |
| X.RAY CBC 25. X-RAY SEROLOGY URINALYSIS DATE (MM/DD/YYYY) ALBUMEN SUGAR CHECK ALL BOXES THAT APPLY OR CHECK N/A PYES NO DATE (MM/DD/YYYY) ALBUMEN SU IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS: SCHIZOPHRENIA PARANOIA OTHER PAYCHOTIC OR MENTAL ILLNESS SUCH AS: SCHIZOPHRENIA PARANOIA OTHER PAYCHOTIC OR MENTAL ILLNESS SUCH AS: SCHIZOPHRENIA OBON SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER MASK PRN N/A TUBE FEEDING N/A DECUBITUS ULCE | 23. NEUROL | LOGICAL | | | | | | 24. AL | LERGY/DF | RUG SENSITI | VITY | | | |
| LAB SEROLOGY URINALYSIS DATE (MM/DD/YYYY) ALBUMEN SUGAR ACETONE CHECK ALL BOXES THAT APPLY OR CHECK N/A 26. IS DEMENTIA THE PRIMARY 27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS 28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 OR OTHERS 29. IS CLIENT A DANGEF OR OTHERS 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SCHIZOPHRENIA PARANOIA YES NO N/A YES OR OTHER 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY N 30. OXYGEN 32. FEEDING N/A IDTHE FEEDING IN/A 33. WOUND 34. FOLEY OR ITEMPOR MASK PRN N/A TUBE FEEDING IN/A IDECUBITUS ULCERS N/A ITEMPOR NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 37. SECONDARY DIAGNOSIS 38. TERTIARY 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 HEAL | | | DATE (MM/D | D/YYYY) | RESULT | | | | CBC DATE (MM/DD/YYYY) | | F | RESULT | | |
| URINALYSIS CHECK ALL BOXES THAT APPLY OR CHECK N/A 26. IS DEMENTIA THE PRIMARY 27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS 28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 29. IS CLIENT A DANGEF OR OTHERS 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS: SCHIZOPHRENIA PRANOIA YES NO N/A YES O N/A YES O N/A YES O OR OTHERS 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS: SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY N MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER 31. OXYGEN 32. FEEDING N/A DECUBITUS ULCERS N/A 34. FOLEY O MASK PRN N/A TUBE FEEDING N/A DECUBITUS ULCERS N/A TEMPOR NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 40. TYPE OF CARE RECOMM | | SEROLOGY | | | | | | | | | | | | |
| 26. IS DEMENTIA THE PRIMARY 27. IS THERE A DIAGNOSIS OF 28. HAS THE RESIDENT RECEIVED 29. IS CLIENT A DANGEF DIAGNOSIS YES NO N/A YES NO N/A 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS: YES YES NO N/A YES NO N/A 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS: OTHER PSYCHOTIC OR MENTAL DISORDER PERSONALITY DISORDER PERSONALITY DISORDER 31. OXYGEN 32. FEEDING N/A 32. FEEDING 33. WOUND 34. FOLEY OF 33. NASK PRN N/A UBE FEEDING N/A DECUBITUS ULCERS N/A TEMPOR 34. FOLEY OF OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 38. TERTIARY 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 HEAL | | URINALYSIS | DATE (MM/DI | D/YYYY) | ALBUMEN | | | SUGAR | | | ACE | ETONE | | |
| DIAGNOSIS MENTAL ILLNESS MENTAL SERVICES WITHIN THE PAST 2 YEARS OR OTHERS 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS UCH AS: OTHER PSYCHOTIC OR MENTAL DISORDER SEADING TO CHRONIC DISABILITY N 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS UCH AS: OTHER PSYCHOTIC OR MENTAL DISORDER SEADING TO CHRONIC DISABILITY N 31. SCHIZOPHRENIA PARANOIA OTHER PSYCHOTIC OR MENTAL DISORDER PERSONALITY DISORDER 32. FEEDING 32. FEEDING N/A 33. WOUND 34. FOLEY OF 33. WASK PRN N/A TUBE FEEDING N/A TEMPOR 33. REFERRING PHYSICIAN 0STOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 33. SECONDARY DIAGNOSIS 0ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 34. TYPE OF CARE RECOMMENDED: Skilled NURSING HOME CARE DOMICILIARY CARE Adult DAY HEAL | | | | | CHECK | ALL BOXES | 5 THAT | APPLY | OR CHEC | K N/A | | | | |
| 0. IS THERE ANY PRESSING EVIDENCE OR 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 1. OXYGEN 32. FEEDING MASK PRN N/A TUBE FEEDING N/A TUBE FEEDING NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 36. PRIMARY DIAGNOSIS 37. SECONDARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 9. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO OMICILIARY CARE ADULT DAY HEAL | DIAGNOSIS MENTAL ILLNESS MI | | | | | | MEN | ENTAL SERVICES WITHIN THE PAST 2 OR OTHERS | | | | | RS | |
| MOOD SWINGS SOMATOFORM DISORDER PANIC OR SEVERE ANXIETY DISORDER PERSONALITY DISORDER 11. OXYGEN 32. FEEDING 33. WOUND 34. FOLEY O MASK PRN N/A TUBE FEEDING N/A DECUBITUS ULCERS N/A TEMPOR NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 30. TYPE OF CARE RECOMMENDED: Skilled NURSING HOME CARE DOMICILIARY CARE Adult day Heal | YES NO N/A YES NO N/A YES NO N/A | | | | | | | | | | | | | |
| MASK PRN N/A TUBE FEEDING N/A DECUBITUS ULCERS N/A TEMPOR NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 37. SECONDARY DIAGNOSIS 38. TERTIARY DIAGNOSIS | | | | M DISORDE | | | | | | | | | | |
| NASAL CANULAR CONTINUIOUS OSTOMY TRACHOSTOMY DRAINING WOUND WOUND CULTURED PERMAN 35. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 37. SECONDARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 9. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 0. TYPE OF CARE RECOMMENDED: Skilled NURSING HOME CARE DOMICILIARY CARE Adult Day Heal | | | | | | | | | | | | | | |
| 36. REFERRING PHYSICIAN 36. PRIMARY DIAGNOSIS 37. SECONDARY DIAGNOSIS 38. TERTIARY DIAGNOSIS 9. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES 0. TYPE OF CARE RECOMMENDED: Skilled NURSING HOME CARE DOMICILIARY CARE | | | | | | | STOM | | | | | | | |
| 19. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO 10. TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEAL | | | | | | | | | | - | | | | <u>.</u> |
| 10. TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEAL | 37. SECONDARY DIAGNOSIS 38. TERTIARY DIAGNOSIS | | | | | | | | | | | | | |
| | | | | | | | | NDITIO | N? []` | YES 🗌 NO | | | | |
| 1. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY | 0. TYPE OF | CARE RECO | MMENDED: | SKILLED | NURSING H | OME CARE | | | | MICILIARY C | ARE | | ULT DAY HEALTH | CARE |
| | 1. MEDICA | TION AND TR | EATMENT ORI | DERS ON A | DMISSION, | CONTINUE | ON SEI | PARAT | E SHEET IF | - NECESSAR | Y | | | |
| 42. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED 43. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED | 2. PRINTEI | D OR TYPED I | NAME OF PRIN | IARY PHYS | SICIAN ASSI | GNED | | 43. SIC | GNATURE | OF PRIMARY | PHYSICIAN | ASSIGN | ED | |

Department of Veterans Affairs

VA FORM 10-10SH

| | PART III - EVALUATION (Select an a | ppropriate number | r in each category) | | | | |
|---|--|----------------------------------|---|--|--|--|--|
| 44. RESIDENT'S NAM | NE (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 A. Bathroom 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 4. State | | | | |
| 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 Number: 3. Irritations (Rash) 4. Open wound 5. Decubitus | WHEEL CHAIR USE | | | | | |
| 46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN 47. DATE: | | | | | | | |
| PHYSICAL THERAPY | (To be completed by Physical Therapist or Referring Physic | ician) 48. Check if | | | | | |
| 49. SENSATION IMPAIRED 50. RESTRICT ACTIVITY 51. PRECAUTIONS 52. FREQUENCY OF TREATM YES NO YES OTHER 52. FREQUENCY OF TREATM | | | | | | | |
| 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 THE | RAPIES 55. SIGNATURE AND TITLE OF | THERAPIST OR PHY | | | | | |
| | PART IV SOCIAL WORK ASSESSMEN | IT (To be completed b | y Social Worker) | | | | |
| 57. PRIOR LIVING ARRANGEMENTS 58. LONG RANGE PLAN | | | | | | | |
| 59. ADJUSTMENT TO | DILLNESS OR DISABILITY 60. PRINT NAME OF | SOCIAL WORKER | 61. SIGNATURE OF SOCIAL WORKER 62. DATE: | | | | |
| 63. REMARKS: | | 1 | | | | | |

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

| Department of Veterans Affairs STATE HOME PRO | VA FORM 10-10SH OGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION | | | | | |
|--|--|--|--|--|--|--|
| PART V VA AUTHORIZ | ATION FOR PAYMENT | | | | | |
| ADMINISTRATIVE REVIEW | CLINICAL REVIEW | | | | | |
| 64. 10-10EZ or 10-10EZR RECEIVED WITH 10-10SH | 77. SERVICE CONNECTED CONDITION BEING ADMITTED FOR: | | | | | |
| | | | | | | |
| 65. DATE ADMITTED TO SVH 66. DATE RECEIVED BY VA | | | | | | |
| | NURSING HOME CARE 78. IS VETERAN BEING ADMITTED DUE TO SC CONDITION: | | | | | |
| NURSING HOME CARE | | | | | | |
| 67. SERVICE CONNECTED CONDITION RATING GREATER OR | YES NO 79. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE: | | | | | |
| EQUAL TO 70%: | | | | | | |
| 68. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON | YES NO | | | | | |
| | DOMICILIARY CARE | | | | | |
| 69. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE: | 80. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY: | | | | | |
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| 70. APPROVED PER DIEM RATE: | 81. DOES HEALTH AND /OR FUNCTIONAL DEFICITS RENDER VETERAN | | | | | |
| | | | | | | |
| ADULT DAY HEALTH CARE | YESNO | | | | | |
| 71. ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE: | 82. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE: | | | | | |
| YES NO | □ YES □ NO | | | | | |
| DOMICILIARY CARE | ADULT DAY HEALTH CARE | | | | | |
| 72. DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCE: | 83. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE: (38 U.S.C. 1720,(F)(1)(A)) | | | | | |
| YES NO | □ YES □ NO | | | | | |
| 73. ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE: | 84. VETERAN APPROVED FOR ADULT DAY HEALTH CARE: | | | | | |
| YES NO, ADDITIONAL ELIGIBILITY REQUIREMENTS | YES NO | | | | | |
| 74. REMARKS: | 85. REMARKS: | | | | | |
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| 75. SIGNATURE OF VA ADMINISTRATIVE REVIEWER 76. DATE: | 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.

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

VA FORM 10-10SH Department of Veterans Affairs 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 6. GENDER-Check the appropriate box 2. DATE ADMITTED-Select the date admitted using the calendar or enter 7. AGE-Age of applicant the date as MM/DD/YYY 8. DATE OF BIRTH-Enter the date of birth in the format MM/DD/YYYY STATE HOME FACILITY ADDRESS- Enter complete address HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR 3. 9. RESIDENT'S NAME-Enter the full name of the person in which this 4 PURPOSES OF DETERMINING ELIGIBILITY FOR DOMILICIARY PER application applies DIEM PAYMENTS-check yes or no SOCIAL SECURITY NUMBER-Enter the full social security number of 5. the applicant 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 28. HAS THE RESIDENT RECEIVED MENTAL SERVICES WHITHIN 11. HEIGHT-Enter the applicant's height THE PAST 2 YEARS-Check yes, no or N/A (not applicable) 12. WEIGHT-Enter the applicant's weight 29. IS CLIENT A DANGER TO SELF OR OTHERS-Check yes, no or N/A 13. TEMP-Enter the applicant's temperature (not applicable) 14. PULSE-Enter the applicant's pulse rate 30. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS 15. BP-Enter the applicant's blood pressure SUCH AS- Check all that apply or check N/A 16. HEAD/EYES/EARS/NOSE AND THROAT-Enter any problems with 31. OXYGEN-Check all that apply or check N/A 32. FEEDING-Check all that apply or check N/A the head, eyes, ears, nose and throat 33. WOUND-Check all that apply or check N/A 17. NECK-Enter any problems with the neck 18. CARDIOPULMONARY-Enter any problems with the heart 34. FOLEY CATHETER-Check all that apply or check N/A 35. REFERRING PHYSICIAN- Enter the name of the referring physician 19. ABDOMEN-Enter any problems with the abdomen 20. GENITOURINARY-Enter any problems with the genitourinary 36. PRIMARY DIAGNOSIS-Enter the primary diagnosis 21. RECTAL-Enter any problems with the rectum 37. SECONDARY DIAGNOSIS-Enter the secondary diagnosis 38. TERTIARY DIAGNOSIS-Enter the tertiary diagnosis 22. EXTREMITIES-Enter any problems with the extremities 23. NEUROLOGICAL-Enter any problems neurologically 24. ALLERGY/DRUG SENSITIVITY-Enter any allergies or sensitivities 39. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION- Enter yes or no 40. TYPE OF CARE RECOMMENDED-Choose the appropriate care 25. X-RAY/LAB-Date of chest x-ray, results; CBC date, result; serology; 41. MEDICATION AND TREATMENT ORDERS ON ADMISSION, urinalysis date, albumen, sugar, acetone 26. IS DEMENTIA THE PRIMARY DIAGNOSIS- Check ves. no or N/A CONTINUE ON SEPARATE SHEET IF NECESSARY- Enter all (not applicable) medications and treatment orders on the applicant. 27. IS THERE A DIAGNOSIS OF MENTAL ILLNESS-Check yes, no or 42. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN N/A (not applicable) 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 50. RESTRICT ACTIVITY- Check yes or no 51. PRECAUTIONS-Check if there is a cardiac or other (for other type application applies 45. SOCIAL SECURITY NUMBER-Enter the full social security number of over the text in the box) the applicant 52. FREQUENCY OF TREATMENT-Enter often the applicant receives physical therapy 53. TREATMENT GOALS-Check all that apply 46. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN-Enter signature 54. ADDITIONAL THERAPIES-Check all that apply SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN- Enter the 47. DATE- Enter date signed by registered nurse or referring physician 55. signature PHYSICAL THERAPY 56. DATE-Enter the date the Therapist or Physician signed (format MM/DD/YYYY) 48. Check the box if new of continued therapy 49. SENSATION IMPAIRED-Check yes or no PART IV SOCIAL WORK ASSESSMENT (To be completed by Social Worker) 57. PRIOR LIVING ARRANGEMENTS 60. PRINT NAME OF SOCIAL WORKER 58. LONG RANGE PLAN 61. SIGNTURE OF SOCIAL WORKER 59. ADJUSTMENT TO ILLNESS OR DISABILITY 62. DATE 63. REMARKS VA FORM

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

VA FORM 10-10SH

Department of Veterans Affairs 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 NURSING HOME CARE 64. 10-10EZ OR 10-10EZR RECIEVED WITH 10-10SH-Check the 78. IS VETERAN BEING ADMITTED DUE TO SERVICE CONNECTED appropriate if the forms were received with the 10-10SH or if the forms CONDITION. Check YES or NO. were completed electronically. 79. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE -65. DATE ADMITTED TO SVH-Enter the date the Veteran was physically Check YES or NO. admitted to the State Veteran's Home 66. DATE RECEIVED BY VA-Enter the date the complete admission DOMICILIARY CARE application was received by the VA. 80. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR NURSING HOME CARE PROVIDED FOR IN THE COMMUNITY- Check YES or NO. 81. DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER 67. SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL TO 70%-Check YES or NO if the Veteran is 70% SC. EMPLOYMENT- Check YES or NO. If Veteran is unable to pursue 68. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED substantially gainful employment and the clinical provider (reviewer) ON INDIVIDUAL UNEMPLOYABILITY?-Check YES or NO. determines the Veteran has health and functioning deficits that require 69. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE-Check domiciliary care in the SVH and the Veteran is capable of performing the following daily living activities: YES or NO 70. APPROVED PER DIEM RATE-Check either, Basic or the Prevailing (1) Perform without assistance daily adulations, such as brushing teeth, bathing, combing hair, and body eliminations. rate. (2) Dress self, with minimum of assistance. ADULT DAY HEALTH CARE (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 71 ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE-Check YES or NO. personally propelled wheelchair. (6) Have voluntary control over body eliminations or control by use of DOMICILIARY CARE an appropriate prosthesis. (7) Share in some measure, however slight, in the maintenance and 72. DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCEoperation of the facility. Indicate if the Veterans annual income exceeds the maximum amount (8) Make rational and competent decisions as to his or her desire to of someone in receipt of Aid & Attendance for the following categories; remain or leave the facility. Single Veteran, Veteran with Spouse/Dependent, Two Veterans 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 Married to Each Other, Surviving Spouse, or Surviving Spouse with One Dependent. questions are answered "No", per diem is not approved. 73. ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE- Enter 82. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE-Check YES if eligible and NO is there are additional eligibility requirements yes or no. 74. REMARKS- Enter any remarks regarding this section. 75. SIGNATURE OF VA ADMINISTRATIVE REVIEWER-Enter signature ADULT DAY HEALTH CARE 76. DATE-Date VA Administrator signed 83. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING CLINICAL REVIEW SECTON HOME CARE: (38 U.S.C. 1720, (F)(1)(A))-Check YES or NO. 84. VETERAN APPROVED FOR ADULT DAY HEALTH CARE: 77. SERVICE CONNECTED CONDITION BEING ADMITTED FOR-IF 85. REMARKS-Enter any remarks regarding this section. necessary, review VA databases such as VISTA, HINQ, VIS or CPRS SIGNATURE OF VA PHYSICIAN/ADVANCED REGISTERED NURSE 86 for Veteran's service-connection condition/rating. Enter the service PRACTITIONER (ARNP) OR PHYSICIAN ASSISTANT (PA)- Enter connected condition the Veteran is being admitted for. 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.