OMB Control No. 2900-0734
Respondent Burden: 5 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

REPORT OF NURSING HOME OR ASSISTED LIVING INFORMATION

NOTE - This form must be filled out in ink or on a typewriter or computer, as it becomes a permanent record in the veteran's folder.

1. VA OFFICE

2. IDENTIFICATION NUMBERS *(C, XC, SS, XSS, V, K, etc.)*

3. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*

4. DATE OF CONTACT *(Month, day, year)*

5. ADDRESS OF VETERAN OR BENEFICIARY, IF OTHER THAN THE VETERAN *(Include number and street or rural route, city or P.O., State and ZIP Code)*

6A. TELEPHONE NUMBER OF VETERAN *(Include Area Code)*

DAY | EVENING

6B. E-MAIL ADDRESS *(If applicable)*

7. NAME OF PERSON CONTACTED

8. TYPE OF CONTACT *(If applicable)*

☐ PERSONAL ☐ TELEPHONE

9. ADDRESS OF PERSON CONTACTED

10. TELEPHONE NUMBER OF PERSON CONTACTED *(Include Area Code)*

☐ I certify that I properly identified my caller using the ID Protocol

11. NURSING HOME/ASSISTED LIVING FACILITY INFORMATION

A. Is _____ ☐ a patient ☐ or resident at this facility?

B. Is the patient under ☐ skilled or ☐ intermediate care ☐ other (If "other" is selected, please specify which Activities of Daily Living (ADLs), if any, the facility provides to the veteran or claimant:

C. Date of admission *(month, day, year)* _____

D. Is the facility Medicaid-approved? ☐ YES ☐ NO

E. Is the facility a state veterans home or VA-contract facility? ☐ YES ☐ NO

F. Has the veteran or claimant applied for medicaid? ☐ YES ☐ NO

G. Is Medicaid coverage pending? ☐ YES ☐ NO

H. Date Medicaid coverage began *(month, day, year)* _____

I. Out-of-pocket NH/AL expenses per day or out-of-pocket expenses per month.

12. For A & A grant under 38 CFR 3.351(c)

A. Is the payee a patient in a nursing home because of mental or physical incapacity? ☐ YES ☐ NO

B. Is the facility an extended care facility licensed by the state to provide skilled or intermediate level nursing care? ☐ YES ☐ NO

13. ADDITIONAL REMARKS

A copy of this form was sent to Power of Attorney of record *(If applicable)*

cc:

DIVISION OR SECTION

EXECUTED BY *(Signature and title)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.576 for routine uses (i.e. civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/21/22/28 Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to respond to the questions on this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.