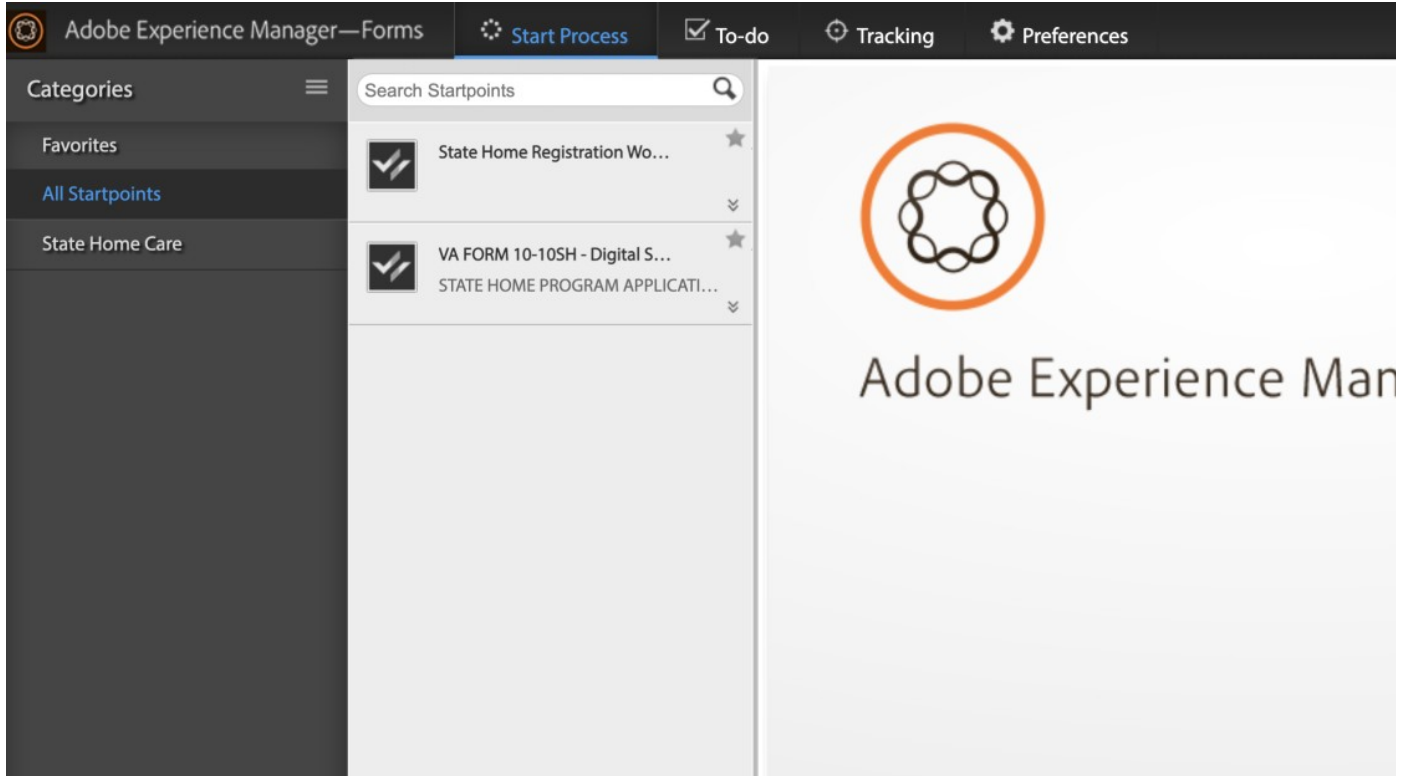


Online AEM 10-10SH Screenshots



State Home Workflow:



Adobe Experience Manager—Forms Start Process To-do Tracking Preferences Help Logout sa testdomain4


Start 10-10 SH Process Details Form Attachments(0) Notes(0)

Search Startpoints

Categories

- Start 10-10 SH Process
- Start 10-10 SH Process
- Start View State Home Users
- State Home Registration Wo...
- Update State Home Address

Online 10-10SH Application for State Home Care (FY 2021 version 4.0.1)



OMB Number: 2900-0160
Estimated Burden: Ave 20 min.
EXP: Oct 31, 2023

DEPARTMENT OF VETERANS AFFAIRS

Online Application for State Home Care

VA's State Home program provides an economical alternative to constructing, maintaining and operating VA facilities for the provision of quality care to eligible Veterans. Under this program, the VA Medical Centers (VAMCs) reimburses State Veteran Homes (SVHs) to defray the cost of providing veterans care. These SVHs provide quality care for eligible veterans in three different levels: Nursing Home Care (NHC), Domiciliary Care, and Adult Day Health Care (ADHC). This form 10-10SH provides the SVHs an Online Application for State Home Care on behalf of the Veteran seeking for care.

Eligibility Determination

Federal law requires SVHs to provide assistance to the Veteran in submitting or renewing their Application for Health Care benefits (Form 10-10EZ) for admission to the State Home. Form 10-10EZ/EZR will include the Veteran's eligibility related information such as military service and income.

[Click here to complete the Online 10-10EZ](#)

[Paperwork Reduction Act and Privacy Act Statement](#) I have read the Paperwork Reduction Act and Privacy Act Statement

[Start the 10-10SH](#)

Save Submit

Start 10-10 SH Process - Multiple SH Details Form Attachments(0) Notes(0)

Online 10-10SH Application for State Home Care (FY 2021 version 4.1.4)

SECTION COMPLETE: PART II PART III Evaluation PART III PT PART IV

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative SH History & Physical Printable 10-10SH Form

General Information

[Skip to Main Content](#)

*STATE HOME ID
SH Test Domain

*STATE HOME FACILITY
SH Test Domain

STATE HOME FACILITY ADDRESS

*STREET
123 Main Street

*CITY
Great Falls

*STATE

Save Submit

Online 10-10SH Application for State Home Care (FY 2021 version 4.0.1)

SECTION PART II PART III PART III PT PART IV PART V PART V
COMPLETE: Evaluation Admin Clinical

No Decision

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative SH History & Physical Printable 10-10SH Form

< History X-Ray Labs Mental Illness Additional Referring Physician Eval >

Skip to Main Content

*HISTORY

*HEIGHT	*WEIGHT	*TEMP	*PULSE	*BP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
*HEAD / EYES / EAR / NOSE / THROAT				<input type="checkbox"/> HEAD/ENT NOT APPLICABLE
<input type="text"/>				
*NECK				<input type="checkbox"/> NECK NOT APPLICABLE
<input type="text"/>				
*CARDIOPULMONARY				<input type="checkbox"/> CP NOT APPLICABLE
<input type="text"/>				

Save Return to Cli... To State Admi... ⋮

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative SH History & Physical Printable 10-10SH Form

< History X-Ray Labs Mental Illness Additional Referring Physician Eval >

Skip to Main Content

CHEST X-RAY	<input type="checkbox"/> CHEST X-RAY NOT APPLICABLE	
*DATE	<input type="text"/>	
*RESULTS	<input type="text"/>	
CBC	<input type="checkbox"/> CBC NOT APPLICABLE	
*DATE	<input type="text"/>	
*RESULTS	<input type="text"/>	
SEROLOGY	<input type="checkbox"/> SEROLOGY NOT APPLICABLE	
<input type="text"/>		
URINALYSIS	<input type="checkbox"/> URINALYSIS NOT APPLICABLE	
*DATE	<input type="text"/>	
*ALBUMIN (mg/dL)	*SUGAR (g/dL)	*ACETONE (mmol/L)
<input type="text"/>	<input type="text"/>	<input type="text"/>

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Previous Section Next Section

Save Return to Cli... To State Admi... ⋮

- History
- X-Ray Labs
- Mental Illness**
- Additional
- Referring Physician
- Eval

Skip to Main Content

***IS DEMENTIA THE PRIMARY DIAGNOSIS?**

- YES
- NO
- NOT APPLICABLE

***IS THERE A DIAGNOSIS OF MENTAL ILLNESS?**

- YES
- NO
- NOT APPLICABLE

***HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS?**

- YES
- NO
- NOT APPLICABLE

***IS CLIENT A DANGER TO SELF OR OTHERS?**

- YES
- NO
- NOT APPLICABLE

***IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS (Check all that apply)**

- SCHIZOPHRENIA
- MOOD SWINGS
- PARANOIA
- SOMATOFORM DISORDER
- PANIC OR SEVERE ANXIETY DISORDER
- PERSONALITY DISORDER
- OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
- NOT APPLICABLE

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Help | Logout | physician testidoma...

Details | Form | History | Attachments(0) | Notes(0)

History | X-Ray Labs | Mental Illness | **Additional** | Referring Physician | Eval

Skip to Main Content

***OXYGEN if mask or cannula, prn /continuous is required**

- MASK
- NASAL CANNULA
- PRN
- CONTINUOUS
- NOT APPLICABLE

***FEEDING**

- TUBE FEEDING
- OSTOMY
- TRACHOSTOMY
- NOT APPLICABLE

***WOUND**

- DECUBITUS ULCERS
- DRAINING WOUND
- WOUND CULTURED
- NOT APPLICABLE

***FOLEY CATHETER**

TEMPORARY PERMANENT NOT APPLICABLE

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Previous Section Next Section

Save Return to Clini... To State Admi... ...

Adobe Experience Manager—Forms Start Process To-do Tracking Preferences Help | Logout | PhyB TestDomain4

Search Tasks Clinical Team Details | Form | History | Attachments(0) | Notes(0)

Enable Bulk Mode

5. TOTAL INCONTINENCE 5. TOTAL INCONTINENCE

6. CATHETER, INDWELLING 6. OSTOMY

***SKIN CONDITION:**

- 1. INTACT
- 2. DRY/FRAGILE
- 3. IRRITATIONS (RASH)
- 4. OPEN WOUND
- 5. DECUBITUS

***WHEELCHAIR USE:**

- 1. INDEPENDENCE
- 2. ASSISTANCE IN DIFFICULT MANEUVERING
- 3. WHEELS A FEW FEET
- 4. UNABLE TO USE
- 5. NA

Registered Nurse or Referring Physician Signature Button

Clear Registered Nurse Referring Physician Sign Button

SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA

DATE SIGNED

mm/dd/yyyy

Return to Clini... To State Admi...

No Decision

Note: SMH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative

SH History & Physical

Printable 10-105H Form



Evaluation Screen 1

Evaluation Screen 2

Physical Therapy

Social Work



Skip to Main Content

*PHYSICAL THERAPY (To be completed by Physical Therapist or Physician/APRN/PA)

NEW REFERRAL CONTINUATION OF THERAPY NOT APPLICABLE

*ADDITIONAL THERAPIES

- O.T.
- SPEECH
- DIETARY
- NOT APPLICABLE

Physical Therapist or Physician/APRN/PA Signature Button

Clear Physical Therapy or Physician/APRN/PA Signature Button

SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA

DATE SIGNED

Previous Page

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Next Section

Save

Return to Clinic

To State Admin.

SECTION COMPLETE:

PART II

PART III Evaluation

PART III PT

PART IV

No Decision

Note: SVH Parts II, III, and IV must be completed and signed before submitting to WMC.
WMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative

SH History & Physical

Printable 10-105H Form

< Evaluation Screen 1 Evaluation Screen 2 Physical Therapy **Social Work** >

Skip to Main Content

SOCIAL WORK ASSESSMENT (To be completed by SVH Social Worker (SW) or Physician (APRN/PA))

*PRIOR LIVING ARRANGEMENTS

*LONG RANGE PLAN

*ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS

*NAME OF SW OR PHYSICIAN/APRN/PA

Social Worker or Physician/APRN/PA Signature Button

Clear Social Worker or Physician/APRN/PA Signature Button

SIGNATURE OF SW OR PHYSICIAN/APRN/PA

DATE SIGNED

mm/dd/yyyy

Previous Page

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Clear

Returns to Clinic

To Clinic Admin

Online 10-10SH Application for State Home Care (FY 2021 version 4.0.1)

SECTION COMPLETE: PART II Evaluation PART III PART III PT PART IV Admin PART V Clinical PART V

No Decision

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative SH History & Physical Printable 10-10SH Form

Evaluation Screen 1 Evaluation Screen 2 Physical Therapy Social Work **Remar**

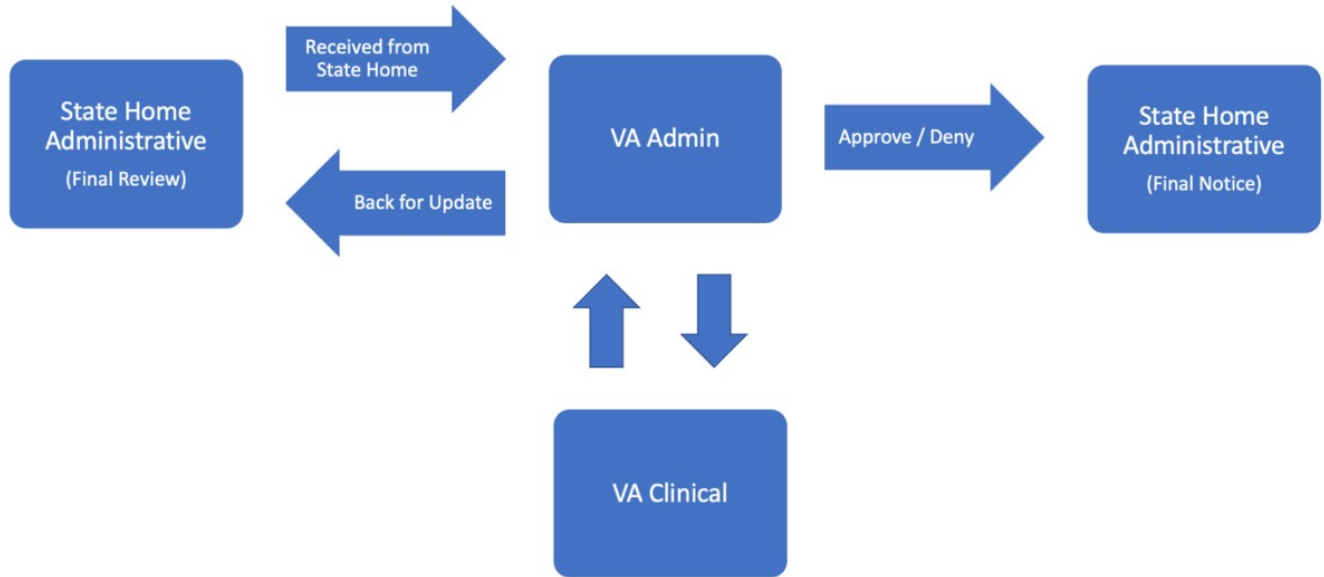
Skip to Main Content

REMARKS

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VAMC Workflow:



Start Process To-do Tracking Preferences Help Logout admin 123

VA Admin Details Form History Attachments(0) Notes(0)

No Decision

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC. VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

State Home Administrative SH History & Physical Printable 10-10SH Form VA Auth for Payment

VA Administrative Review Signature

*Date Admitted To SVH
09/20/2021

*Date Received By VA
09/23/2021

THIS ADMISSION PACKAGE WAS SUBMITTED FOR TYPE OF CARE RECOMMENDED BY SVH:

NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE

*THIS SVH IS A VA-RECOGNIZED HOME ESTABLISHED BY THE STATE TO PROVIDE THE FOLLOWING LEVEL OF CARE?

NURSING HOME CARE DOMICILIARY CARE ADULT DAY HEALTH CARE

GENERAL CRITERIA

*HAS VETERAN BEEN BARRED FROM RECEIVING VA PENSION, COMPENSATION OR DEPENDENCY AND INDEMNITY COMPENSATION BASED ON THE CHARACTER OF A DISCHARGE FROM MILITARY SERVICE?

Yes No

*DID APPLICANT SERVE IN THE ACTIVE MILITARY, NAVAL, OR AIR SERVICE ON ACTIVE DUTY FOR PURPOSES OTHER THAN "ACTIVE DUTY FOR TRAINING"?

Save Clinical Review Return to SH

State Home Administrative

SH History & Physical

Printable 10-10SH Form

VA Auth for Payment

VA Administrative Review

Eligibility

Signature

*Does Veteran Meet One of the Following Categories? Check All Categories That Apply.

VETERAN WITH SERVICE-CONNECTED DISABILITIES

VETERANS WHO ARE FORMER PRISONERS OF WAR, WHO WERE AWARDED THE PURPLE HEART, OR WHO WERE AWARDED THE MEDAL OF HONOR UNDER 10 U.S.C. 3741, 6241, or 8741 or 14 U.S.C. 491

VETERAN WHO WAS DISCHARGED OR RELEASED FROM ACTIVE MILITARY SERVICE FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY

VETERAN WHO RECEIVE DISABILITY COMPENSATION UNDER 38 U.S.C. 1151

VETERAN WHOSE ENTITLEMENT TO DISABILITY COMPENSATION IS SUSPENDED BECAUSE OF THE RECEIPT OF RETIRED PAY

VETERAN WHOSE ENTITLEMENT TO DISABILITY COMPENSATION IS SUSPENDED PURSUANT TO 38 U.S.C. 1151, BUT ONLY TO THE EXTENT THAT SUCH VETERANS' CONTINUING ELIGIBILITY FOR NURSING HOME CARE IS PROVIDED FOR IN THE JUDGMENT OR SETTLEMENT DESCRIBED IN 38 U.S.C. 1151

VETERAN WHO VA DETERMINES ARE UNABLE TO DEFRAY THE EXPENSES OF NECESSARY CARE AS SPECIFIED UNDER 38 U.S.C. 1722(a)

Online 10-10SH Application for State Home Care (FY 2021 version 4.1.1)

SECTION COMPLETE:

PART II

PART III

PART III PT

PART IV

PART V

PART V

Evaluation

Admin

Clinical

Clinically Approved

Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.

VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.

Veteran Name: Franklin Joseph Lawson

State Home Administrative

SH History & Physical

Printable 10-10SH Form

VA Auth for Payment

VA Administrative Review

Eligibility

Signature

VA Clinical Review

VA Administrative Signature

Remarks

VA Admin remarks here.

VA Sign Button

Clear VA Sign

SIGNATURE OF VA ASSIGNED

DATE SIGNED

06/28/2022

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Previous Section

Save

Clinical Review

Return to SH

...

Remarks

Empty text box for remarks.

VA Clinical Sign Button

Clear VA Clinical Sign

SIGNATURE OF VA ASSIGNED

Empty signature line.

DATE SIGNED

Empty date line.

Back

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Entering data in these screens in the online AEM 10-10SH form populates all the fields and generate the 10-10SH.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
Expiration Date: 10-31-2023

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY
2. DATE ADMITTED (MM/DD/YYYY)

3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)

4. RESIDENT'S NAME (Last, First, Middle)

5. SOCIAL SECURITY NUMBER 6. GENDER M F 7. AGE 8. DATE OF BIRTH (MM/DD/YYYY) 9. ADVANCED MEDICAL DIRECTIVE NO YES

10. 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)

11. HISTORY

12. HEIGHT 13. WEIGHT 14. TEMP 15. PULSE 16. BP 17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK 19. CARDIOPULMONARY

20. ABDOMEN 21. GENITOURINARY

22. RECTAL 23. EXTREMITIES

24. NEUROLOGICAL 25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/LAB

CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A	CBC	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A
SEROLOGY							<input type="checkbox"/> N/A
URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN		ACETONE		SUGAR	<input type="checkbox"/> N/A

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS YES NO N/A 28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS YES NO N/A 29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS YES NO N/A 30. IS CLIENT A DANGER TO SELF OR OTHERS YES NO N/A

31. 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 N/A

32. OXYGEN MASK PRN CONTINUOUS NASAL CANNULA N/A 33. FEEDING TUBE FEEDING OSTOMY TRACHEOSTOMY N/A 34. WOUND DECUBITUS ULCERS DRAINING WOUND WOUND CULTURED N/A 35. FOLEY CATHETER TEMPORARY PERMANENT N/A

36. REFERRING PHYSICIAN 37. PRIMARY DIAGNOSIS

38. SECONDARY DIAGNOSIS 39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? YES NO UNKNOWN

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

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

43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA 44. SIGNATURE OF SVH PHYSICIAN/APRN/PA

Note: This field cannot be signed without first filling out item numbers 36 through 43. After signing, all fields in Part 2 will become locked and read only.