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Department of Veterans Affairs

CLAIM FOR INCREASED PER DIEM PAYMENT FOR VETERANS AWARDED RETROACTIVE SERVICE CONNECTION

GENERAL INFORMATION

1. VISN	2. STATION NUMBER	3. FOR MONTH ENDING	4. REPORT QUARTER	5. FISCAL YEAR

6. TO *(Enter VA Facility)*	7. FROM *(Enter Level of Care and State Home)*

8. PAY TO

RETROACTIVE CLAIM INFORMATION

9. Initial of Last Name and Last 4 of SSN (a)	10. Month and Year *(MM/YYYY)* (b)	11. Days of Care Claimed (c)	12. Basic Per Diem Rate Paid (d)	13. Total Amount Claimed (e)	14. Daily Cost of Care Claimed (f)	15. FY Prevailing Per Diem Rate (g)	16. Amount Claimed at the Service Connected Rate (h)	17. Amount Due (i)
							18. Total Per Diem Claimed	

19. REMARKS

I certify that this report is correct, that all residents included in the report were physically present during the period for which Federal Aid is claimed, except for authorized absences for which the VA paid per diem.

20. SIGNATURE OF SVH ADMINISTRATOR	PRINTED NAME AND TITLE: SIGNATURE: DATE *(MM/DD/YYYY)*:
21. SIGNATURE OF SVH EMPLOYEE WHEN APPLICABLE	PRINTED NAME AND TITLE: SIGNATURE: DATE *(MM/DD/YYYY)*:

TOTAL AMOUNT APPROVED BY VA FOR RETROACTIVE PAYMENT

22. SIGNATURE OF VA APPROVING OFFICIAL	PRINTED NAME AND TITLE: SIGNATURE: DATE *(MM/DD/YYYY)*:

ACCOUNTING CERTIFICATION - AUDIT BLOCK

23. OBLIGATION NUMBER	24. AMOUNT DUE

25. SIGNATURE OF AUDITOR	PRINTED NAME AND TITLE: SIGNATURE: DATE *(MM/DD/YYYY)*:

VETERAN INFORMATION

All Veterans under VA contract with SVHs are not authorized for retroactive Per Diem payment

26. Name of Veteran (a)	27. Last 4-Digit of SSN (b)	28. SC Award Effective Date *(MM/DD/YYYY)* (c)	29. SC Disability (d)	30. SC Rating (e)

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 may be entitled. This information is collected under the authority of Title 38 CFR Parts 51. The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741-1743, and 1745. 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.

INSTRUCTION SHEET: VA FORM 10-5588A

CLAIM FOR INCREASED PER DIEM PAYMENT FOR VETERANS AWARDED RETROACTIVE SERVICE CONNECTION

Completion of this form by State Veteran Home (SVH) to VA for balanced due of a Service Connection (SC) Veteran and is intended to reduce burden hours for State Homes claiming retroactive payment.

The VA needs the SVH to submit with the retroactive invoice a letter indicating they have or will reimburse any payer sources they have collected from on behalf of the Veteran. Also, include a copy of the VBA Service Connected Notification letter for SC rating.

1. VISN - Enter the Veterans Integrated Service Networks (VISN) number.
2. Station Number - Enter the station number where the VA Medical Center of Jurisdiction is located.
3. For Month Ending - Enter the last month and year for the report. Multiple months can be logged on this form within the same quarter and Fiscal Year. For example, a single 10-5588A can be used to pay the difference for days of care from October to December 2021; enter Dec 2021.
4. Report Quarter - Enter the Federal Fiscal Quarter the report is for. The Federal Fiscal Year starts on October first.
5. Fiscal Year - The claim period is based on a Federal Fiscal Year from October to September.
6. To - Enter Name, City, and State of the VA Medical Center of Jurisdiction (not the Health Care System).
7. From - Enter Level of Care, State Home Name, City, and State. For example: Level of Care of Nursing Home Care, use abbreviation “NHC”.
8. Pay To - Enter the Name, City, and State where the payment is to be sent.

RETROACTIVE CLAIM INFORMATION

9. Initial of Last Name and Last 4 of SSN, column (a) - Enter the first initial of the last name and the last four digits of the Veteran's Social Security Number.
10. Month and Year of Claim, column (b) - Enter the month and year for the month being claimed.
11. Days of Care Claimed, column (c) - Enter the number of days of care per diem is being claimed for the month indicated in item (b). Do not enter more than one month of days of care per line.
12. Basic Per Diem Rate Paid, column (d) - Enter the basic per diem rate paid in column (e) from the original 10-5588 invoice.
13. Total Amount Claimed, column (e) - Multiply column (c) times column (d).
14. If filing for a Nursing Home Care retroactive payment for periods after February 1, 2013 leave this block blank as the prevailing rate will be paid rather than the lesser of either the daily cost of care or prevailing rate. Daily Cost of Care Claimed, column 14(f) - Enter the daily cost of care reported on the original 10-5588. If the SVH used an average daily cost of care or allowable cost from the prior year in the original 10-5588 claim when completing this retroactive form, enter the amount from the original 10-5588 and provide supporting documentation to support this claim. When filing for an Adult Day Health Care (ADHC) retroactive payment, leave column 14(f) block blank.
15. Fiscal Year Prevailing Rate, column (g) - Enter the prevailing rate for the Fiscal Year for which the retroactive claim is being requested.
16. For retroactive claims from February 2, 2013 forward, leave column (f) (daily cost of care) blank and multiply column (c) (days of care) by column (g) (prevailing per diem rate). Amount Claimed at the Service Connected Rate, column (h); if the retroactive claim is for a period prior to February 2, 2013, multiply column (c) (days of care) by the lesser of either columns (f) (daily cost of care claimed) or (g) (prevailing per diem rate). Note: All per diem paid after February 2, 2013 should be the prevailing rate times the days of care. For ADHC, retroactive payment only goes back to the date of PL 115-159, which was signed, March 27, 2018.
17. Amount Due - Subtract column (e) (total amount claimed) from column (h) (amount claimed at the service connected rate).
18. Total Per Diem Claimed - Add the amounts from item 17 (i).
19. Remarks - Provide any supporting comments regarding the claims above.

CERTIFICATION OF STATE HOME PERSONNEL

20. Signature of SVH Administrator - Print name and title of SVH Administrator; sign and date.
21. Signature of State Employee When Applicable - Print name and title of State Employee, sign and date. When the facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time, on site basis. This State employee must certify that the information in the report is correct by signing and dating the report. If the facility is under contract, the signature of the SVH Administrator is not required.

TOTAL AMOUNT APPROVED BY VA FOR RETROACTIVE PAYMENT AND AUDIT BLOCK

22. Signature of VA Approving Official - Print name and title of VA Approving Official, then sign and date.
23. Obligation Number - Enter prevailing rate Obligation Number paid against. For example, a retro paid in FY 2021 for a SC with effective date of July 2014, the obligation would be paid with FY 2021 fund using obligation number for that station's FY 2021.
24. Amount Due - Enter total amount of per diem for payment due.
25. Signature of Auditor - Print name and title of Auditor, sign and date.

VETERAN INFORMATION

26. Name of Veteran - Enter the last name, first name, and middle initial.
27. SSN - Enter the last four digits of the Veteran's Social Security Number.
28. Service-Connected Award Date - Enter the effective date of service-connected VBA combined rating.
29. Service Connected (SC) Disability - Enter the medical condition for the increased SC Disability rating. Note: if more than one rating was increased to create the combine rating, enter both on same line (example Hearing, Cardiovascular).
30. Service Connected (SC) Rating - Enter the new combined SC Disability rating awarded (percentage).