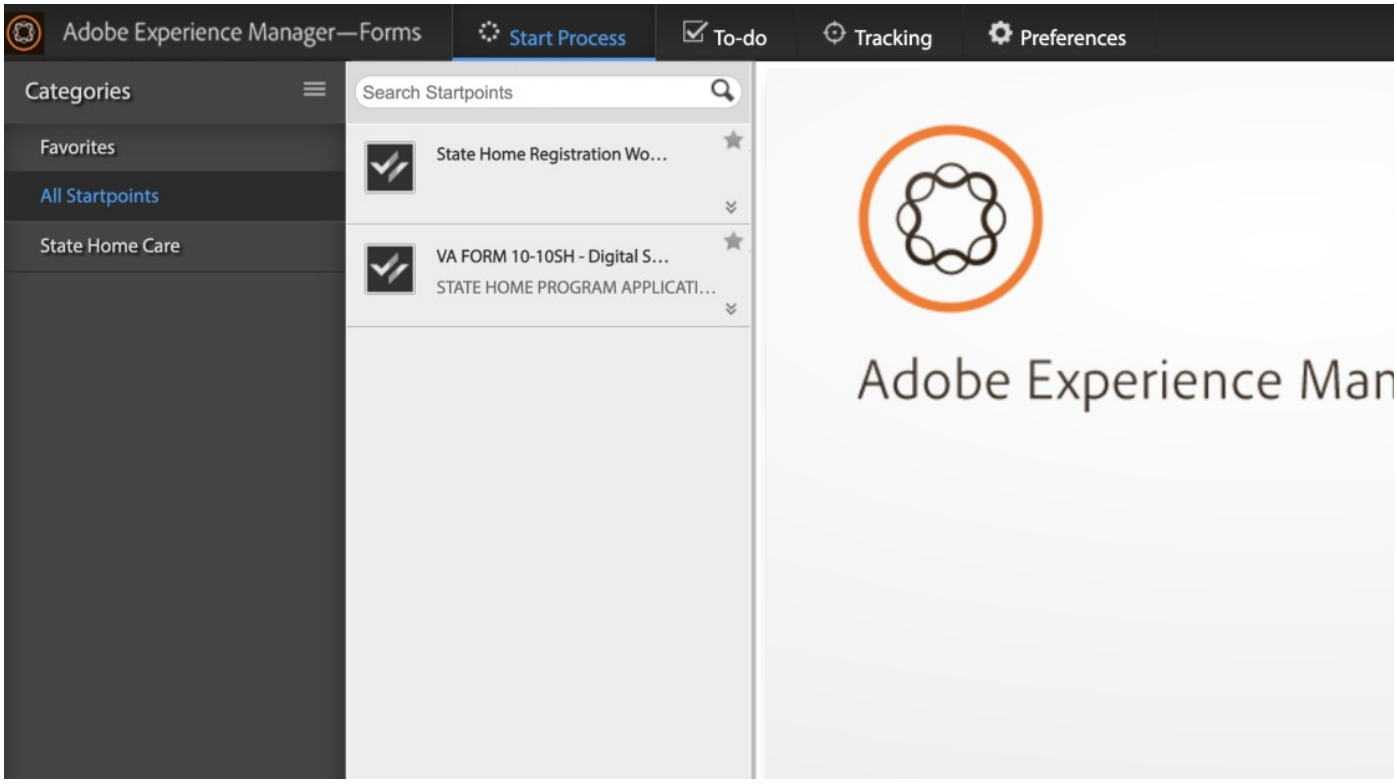
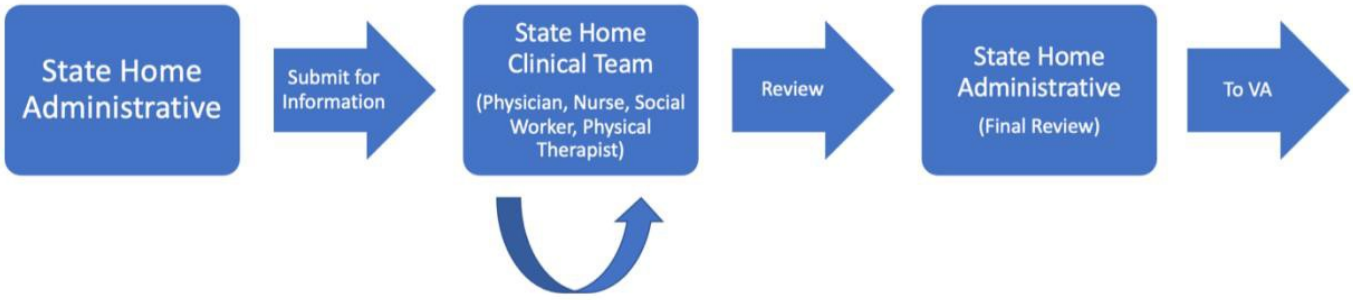
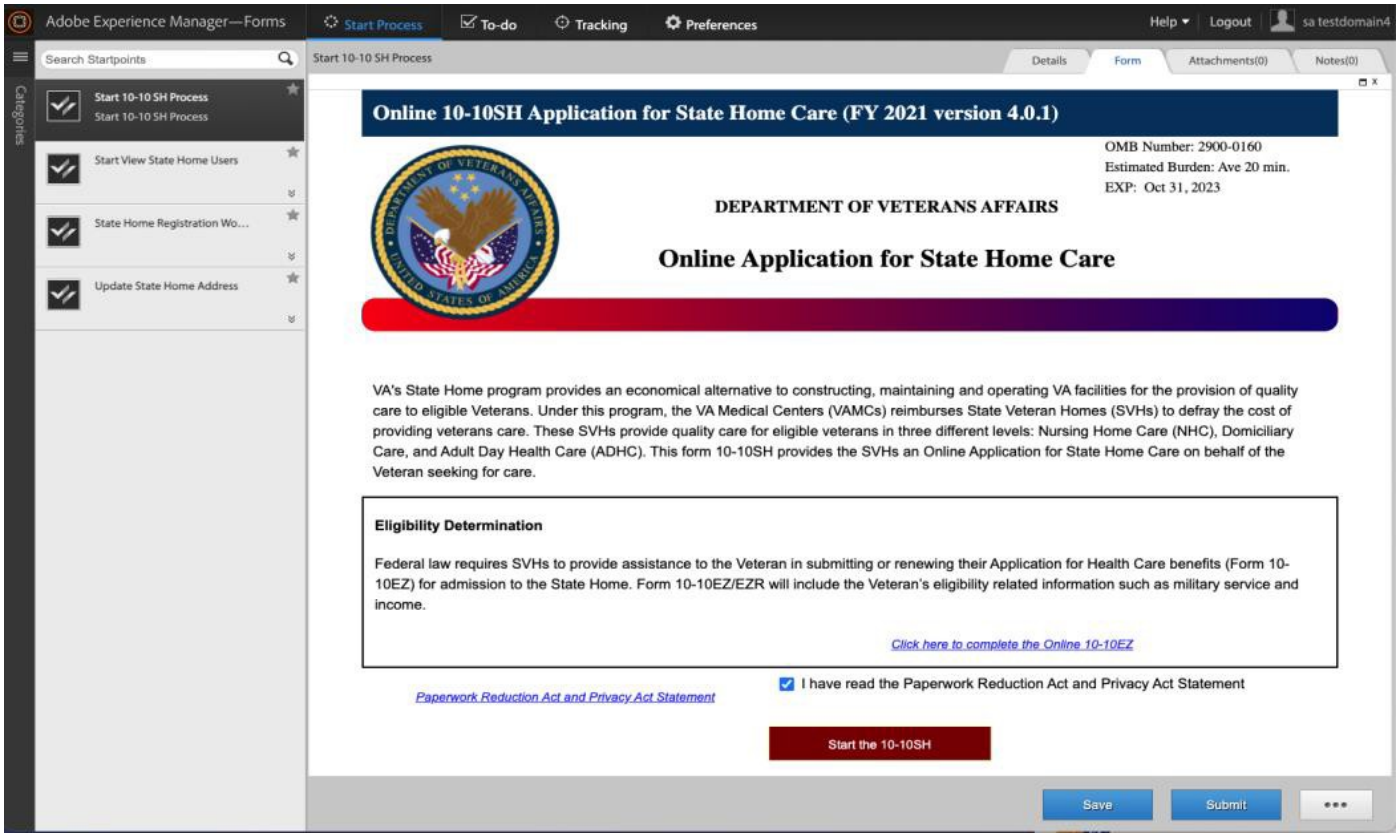
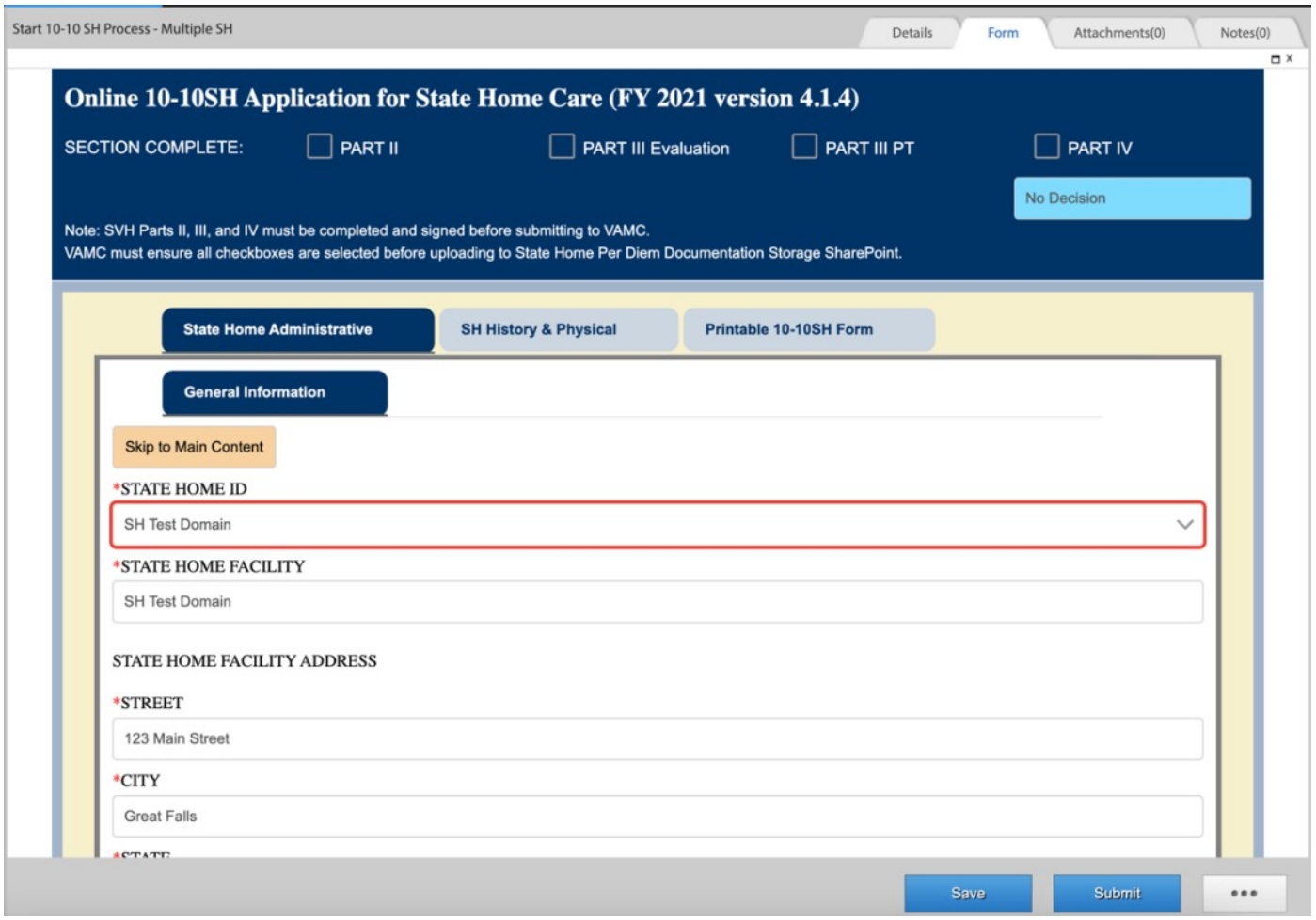
Online AEM 10-10SH Screenshots

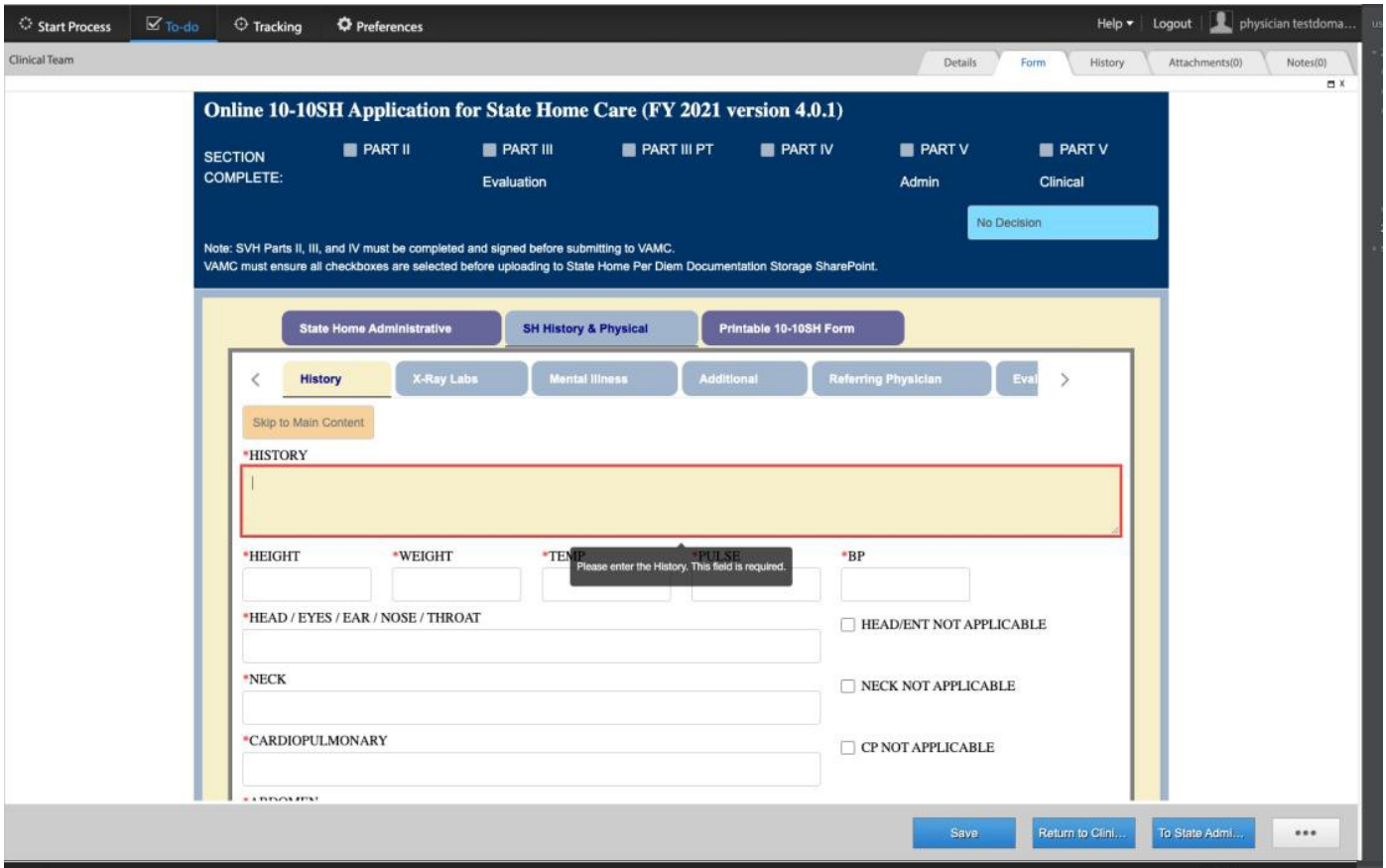


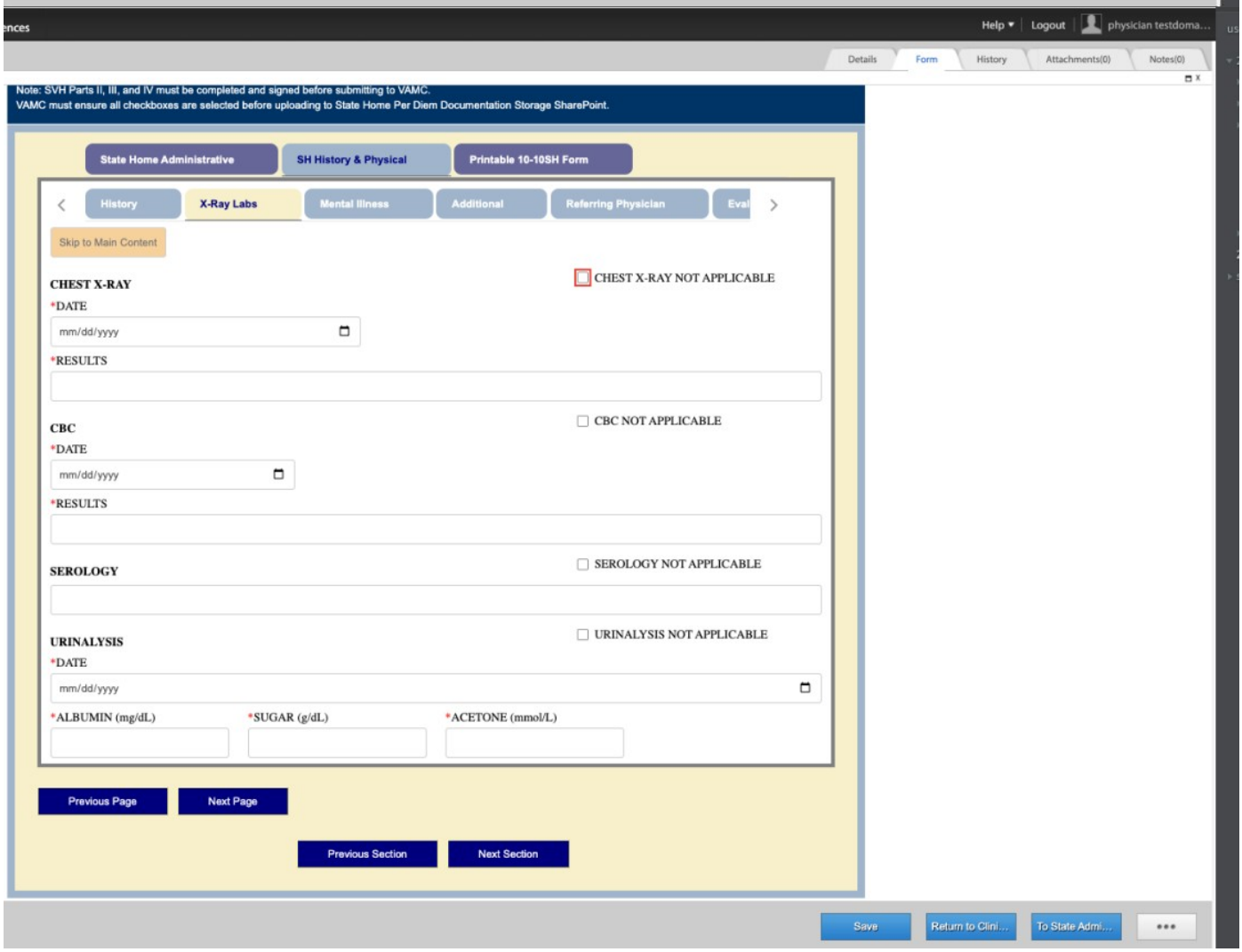
State Home Workflow:

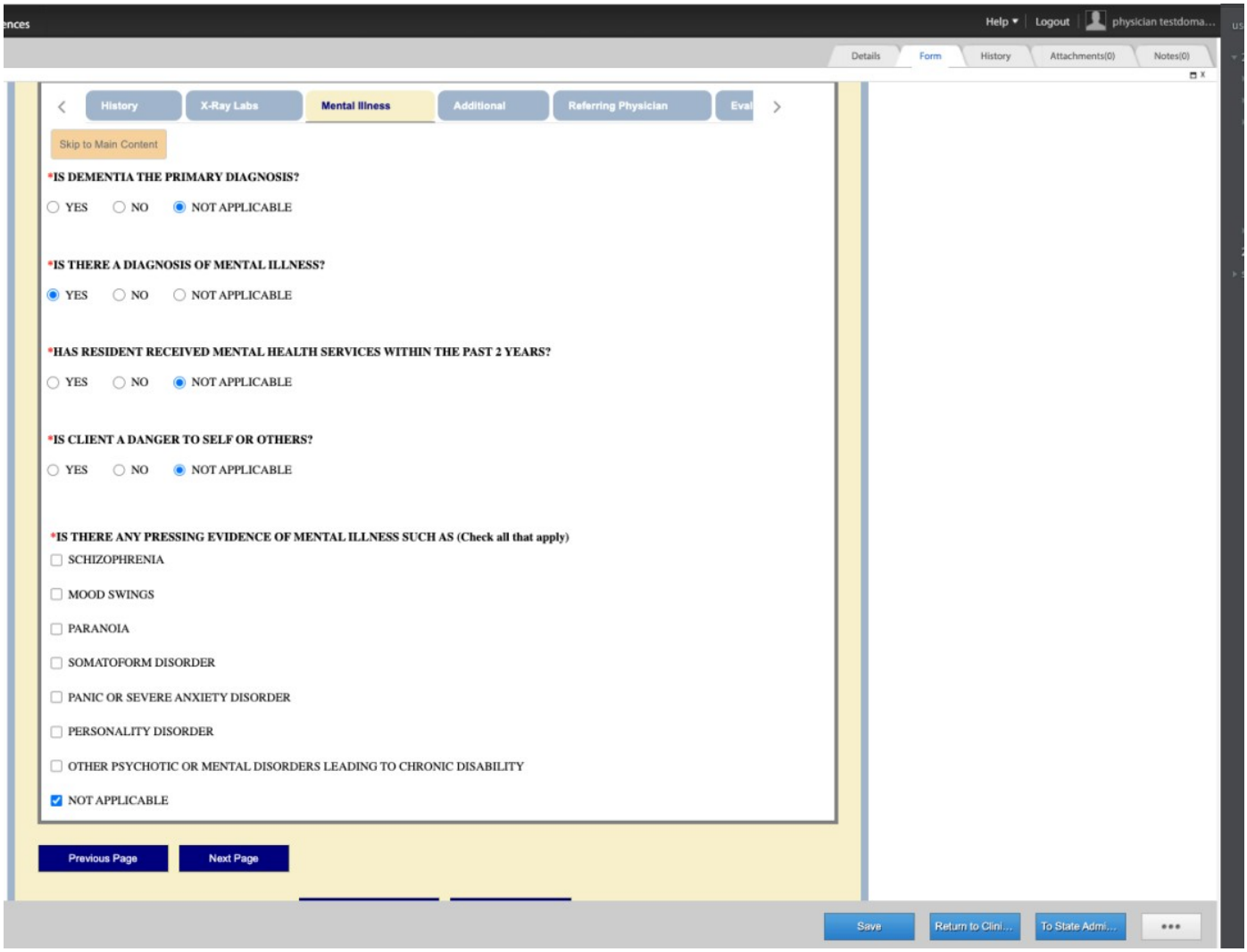


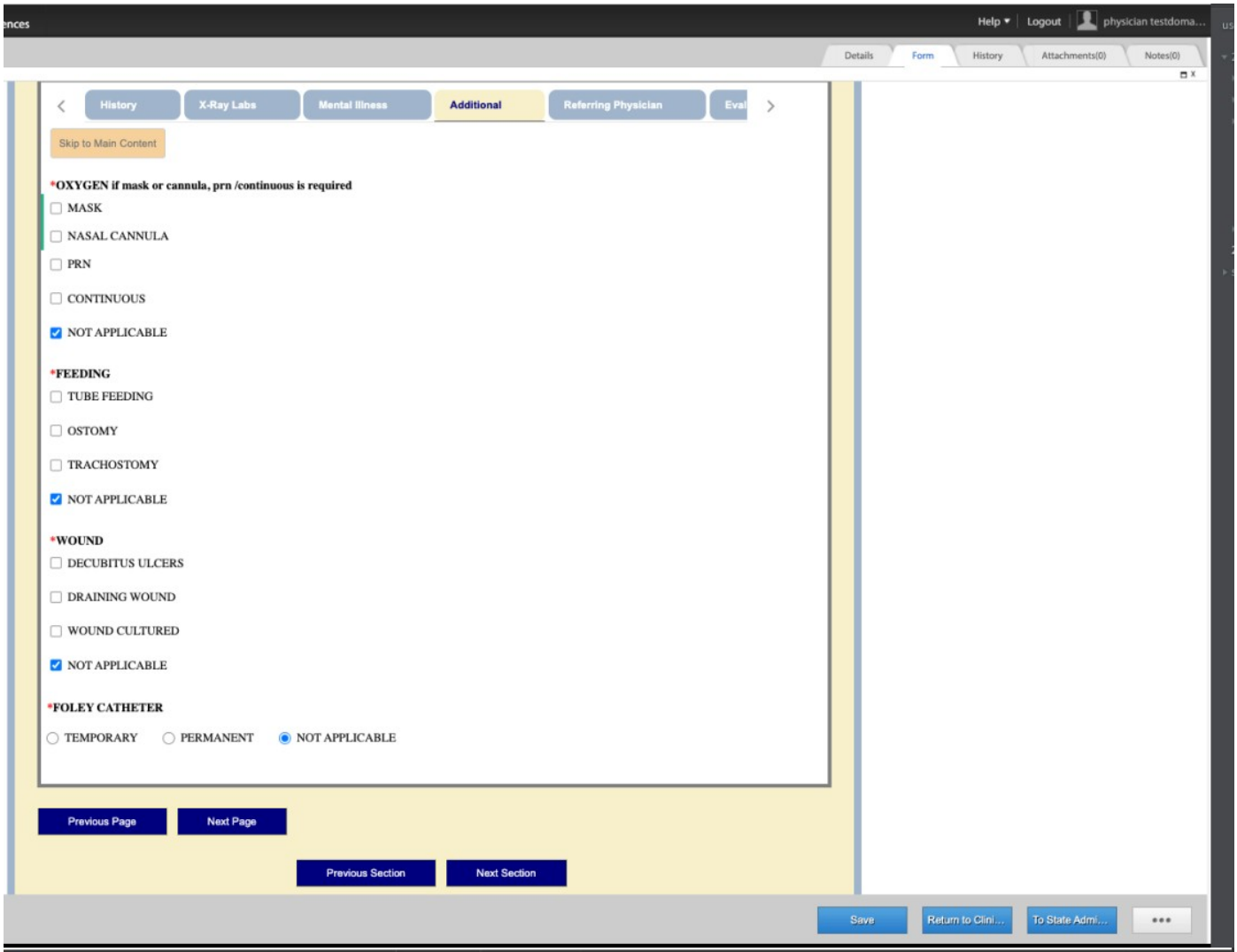

Adobe Experience Manager—Forms
Start Process
To-do
Tracking
Preferences
Help
Logout
sa testdomain4
Search Startpoints
Categories
Start 10-10 SH Process
Start 10-10 SH Process
Start View State Home Users
State Home Registration Wo...
Update State Home Address
Start 10-10 SH Process
Details
Form
Attachments(0)
Notes(0)
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

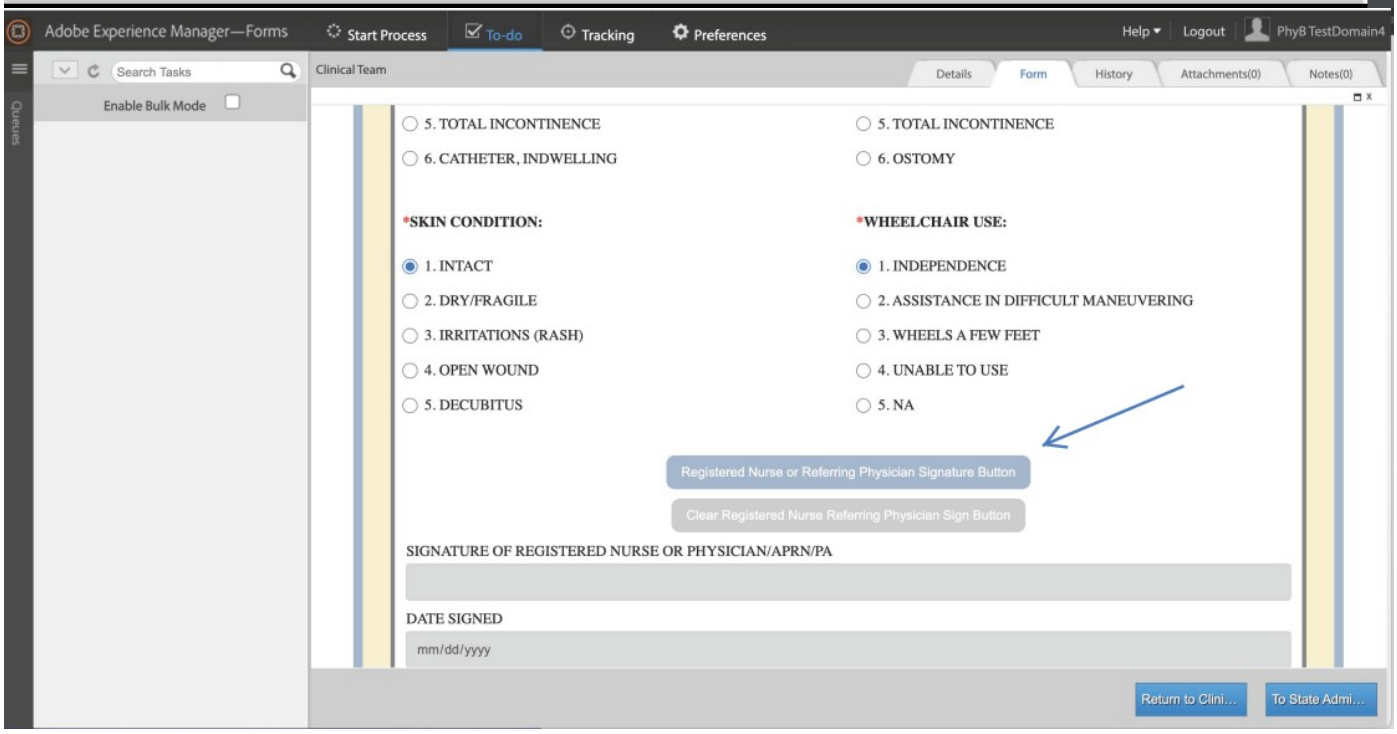

Start 10-10 SH Process - Multiple SH
Details
Form
Attachments(0)
Notes(0)
Online 10-10SH Application for State Home Care (FY 2021 version 4.1.4)
SECTION COMPLETE:
PART II
PART III Evaluation
PART III PT
PART IV
No Decision
Note: SVH Parts II, III, and IV must be completed and signed before submitting 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
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
Save
Submit

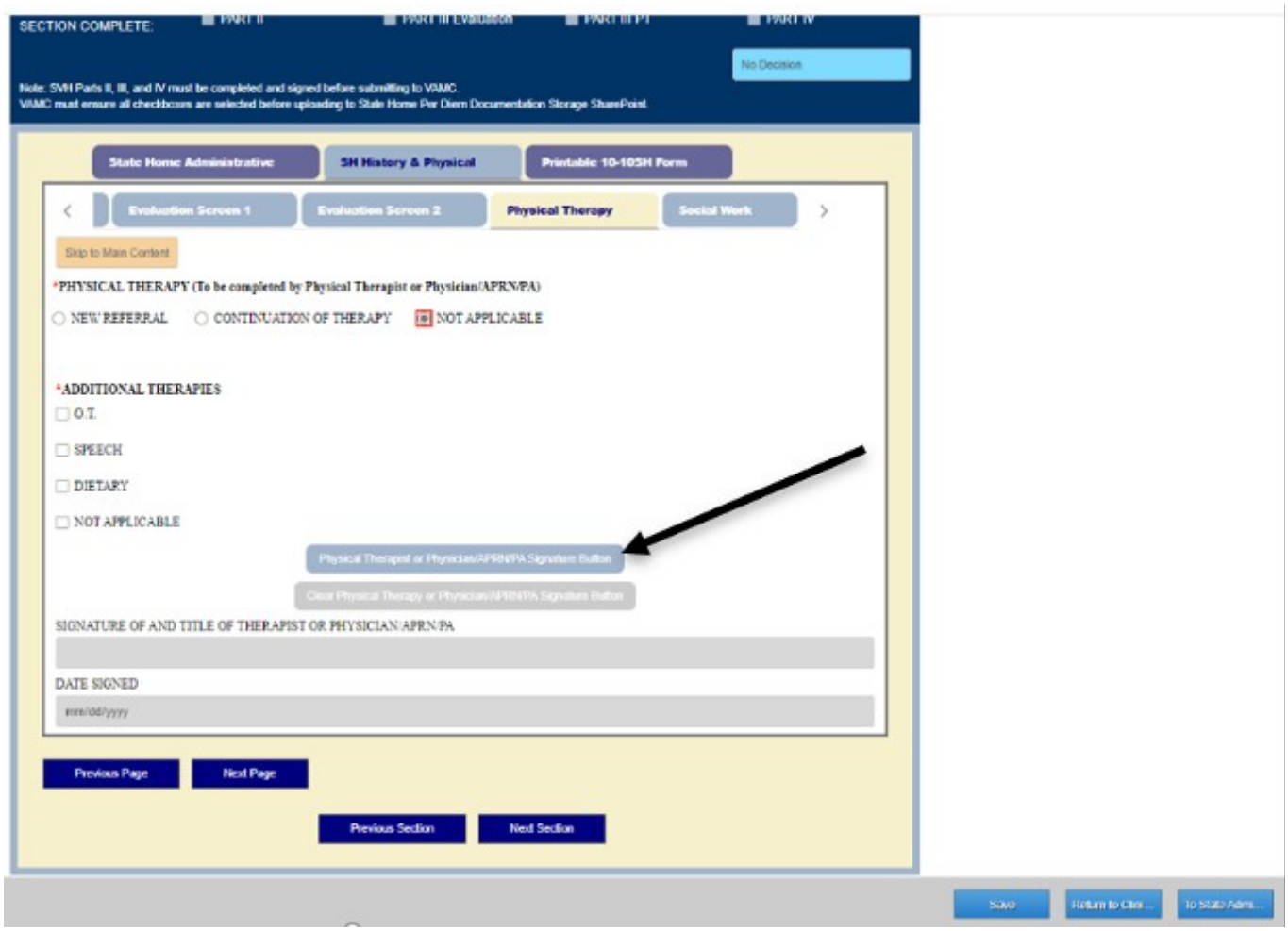

Start Process
To-do
Tracking
Preferences
Help
Logout
physician testdoma...
Clinical Team
Details
Form
History
Attachments(0)
Notes(0)
Online 10-10SH Application for State Home Care (FY 2021 version 4.0.1)
SECTION COMPLETE:
PART II
PART III Evaluation
PART III PT
PART IV
PART V Admin
PART V Clinical
No 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
Skip to Main Content
*HISTORY
Please enter the History. This field is required.
*HEIGHT
*WEIGHT
*TEMP
*PULSE
*BP
*HEAD / EYES / EAR / NOSE / THROAT
HEAD/ENT NOT APPLICABLE
*NECK
NECK NOT APPLICABLE
*CARDIOPULMONARY
CP NOT APPLICABLE
Save
Return to Clini...
To State Admi...

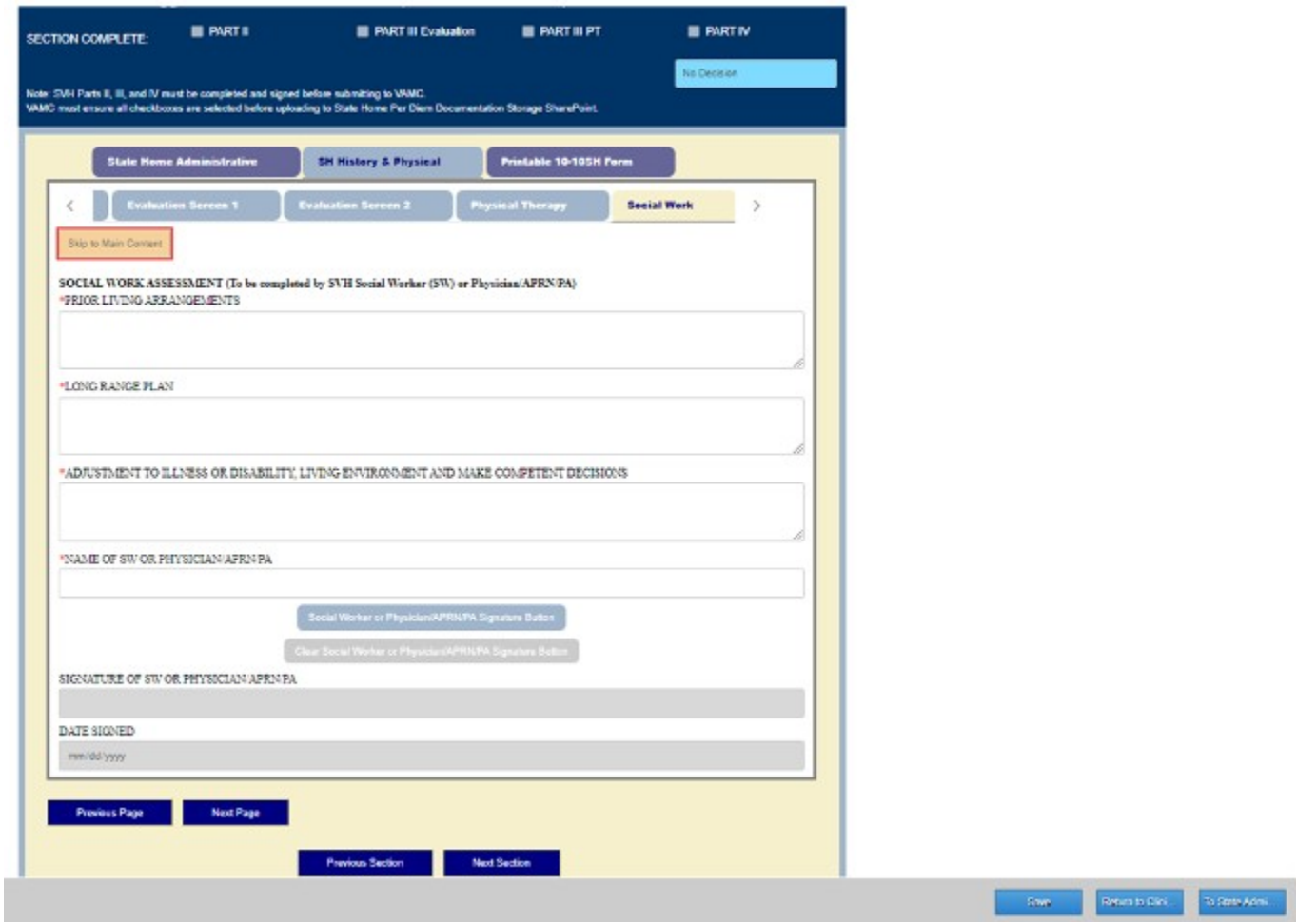

Help
Logout
physician testdoma...
Details
Form
History
Attachments(0)
Notes(0)
Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.
State Home Administrative
SH History & Physical
Printable 10-10SH Form
History
X-Ray Labs
Mental Illness
Additional
Referring Physician
Skip to Main Content
CHEST X-RAY
CHEST X-RAY NOT APPLICABLE
*DATE
mm/dd/yyyy
*RESULTS
CBC
CBC NOT APPLICABLE
*DATE
mm/dd/yyyy
*RESULTS
SEROLOGY
SEROLOGY NOT APPLICABLE
URINALYSIS
URINALYSIS NOT APPLICABLE
*DATE
mm/dd/yyyy
*ALBUMIN (mg/dL)
*SUGAR (g/dL)
*ACETONE (mmol/L)
Previous Page
Next Page
Previous Section
Next Section
Save
Return to Clini...
To State Admi...

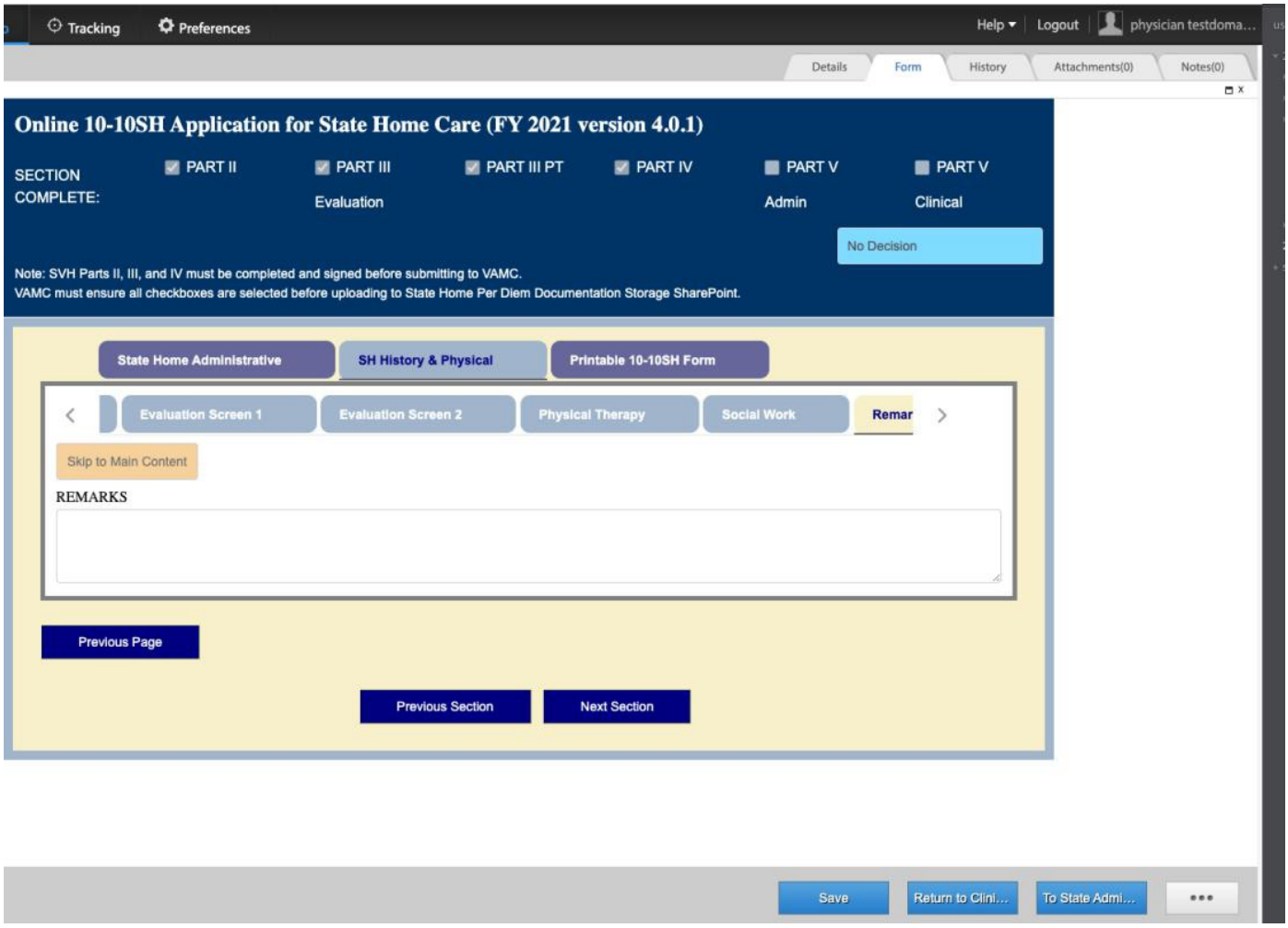

Help
Logout
physician testdoma...
Details
Form
History
Attachments(0)
Notes(0)
History
X-Ray Labs
Mental Illness
Additional
Referring Physician
Skip to Main Content
*IS DEMENTIA THE PRIMARY DIAGNOSIS?
YES NO NOT APPLICABLE
*IS THERE A DIAGNOSIS OF MENTAL ILLNESS?
YES NO NOT APPLICABLE
*HAS RESIDENT RECEIVED 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
Previous Page
Next Page
Save
Return to Clini...
To State Admi...


Help
Logout
physician testdoma...
Details
Form
History
Attachments(0)
Notes(0)
History
X-Ray Labs
Mental Illness
Additional
Referring Physician
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
Previous Page
Next Page
Previous Section
Next Section
Save
Return to Clini...
To State Admi...

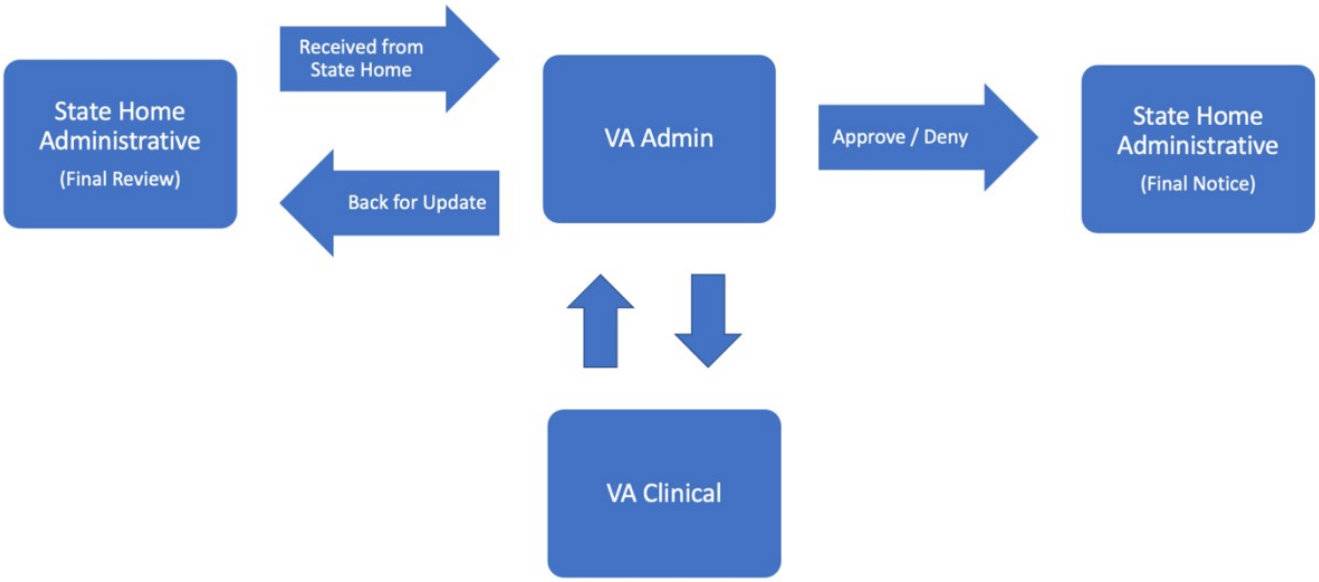

Adobe Experience Manager—Forms
Start Process
To-do
Tracking
Preferences
Help
Logout
PhyB TestDomain4
Search Tasks
Enable Bulk Mode
Clinical Team
Details
Form
History
Attachments(0)
Notes(0)
5. TOTAL INCONTINENCE
6. CATHETER, INDWELLING
5. TOTAL INCONTINENCE
6. OSTOMY
*SKIN CONDITION:
1. INTACT
2. DRY/FRAGILE
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...

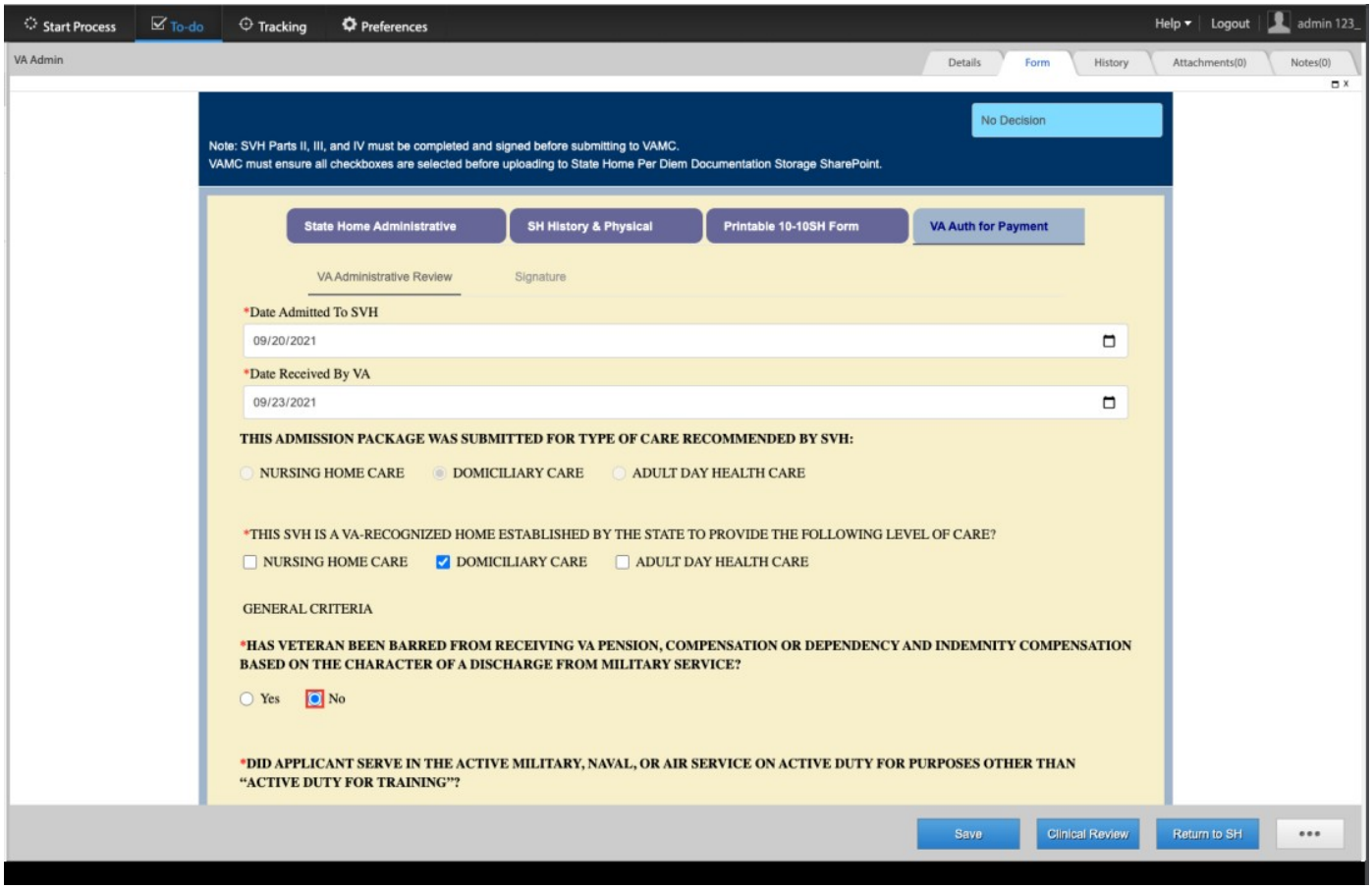

SECTION COMPLETE:
PART II
PART III Evaluation
PART III PT
PART IV
No Decision
Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.
State Home Administrative
SH History & Physical
Printable 10-10SH Form
Evaluation Screen 1
Evaluation Screen 2
Physical Therapy
Social Work
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
mm/dd/yyyy
Previous Page
Next Page
Previous Section
Next Section
Save
Return to Clini...
to State Adm...

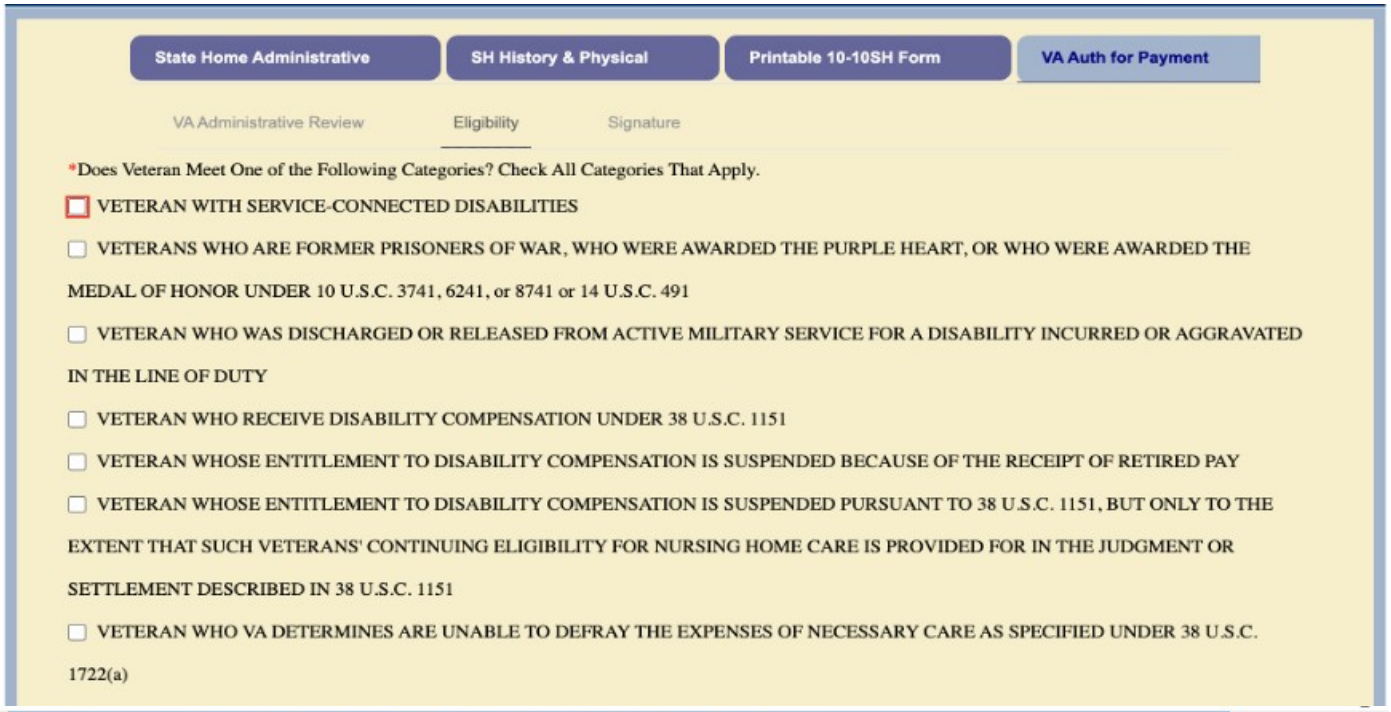

SECTION COMPLETE:
PART II
PART III Evaluation
PART III PT
PART IV
No Decision
Note: SVH Parts II, III, and IV must be completed and signed before submitting to VAMC.
VAMC must ensure all checkboxes are selected before uploading to State Home Per Diem Documentation Storage SharePoint.
State Home Administrative
SH History & Physical
Printable 10-10SH Form
Evaluation Screen 1
Evaluation Screen 2
Physical Therapy
Social Work
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
Next Page
Previous Section
Next Section
Save
Return to Clini
To State Admin

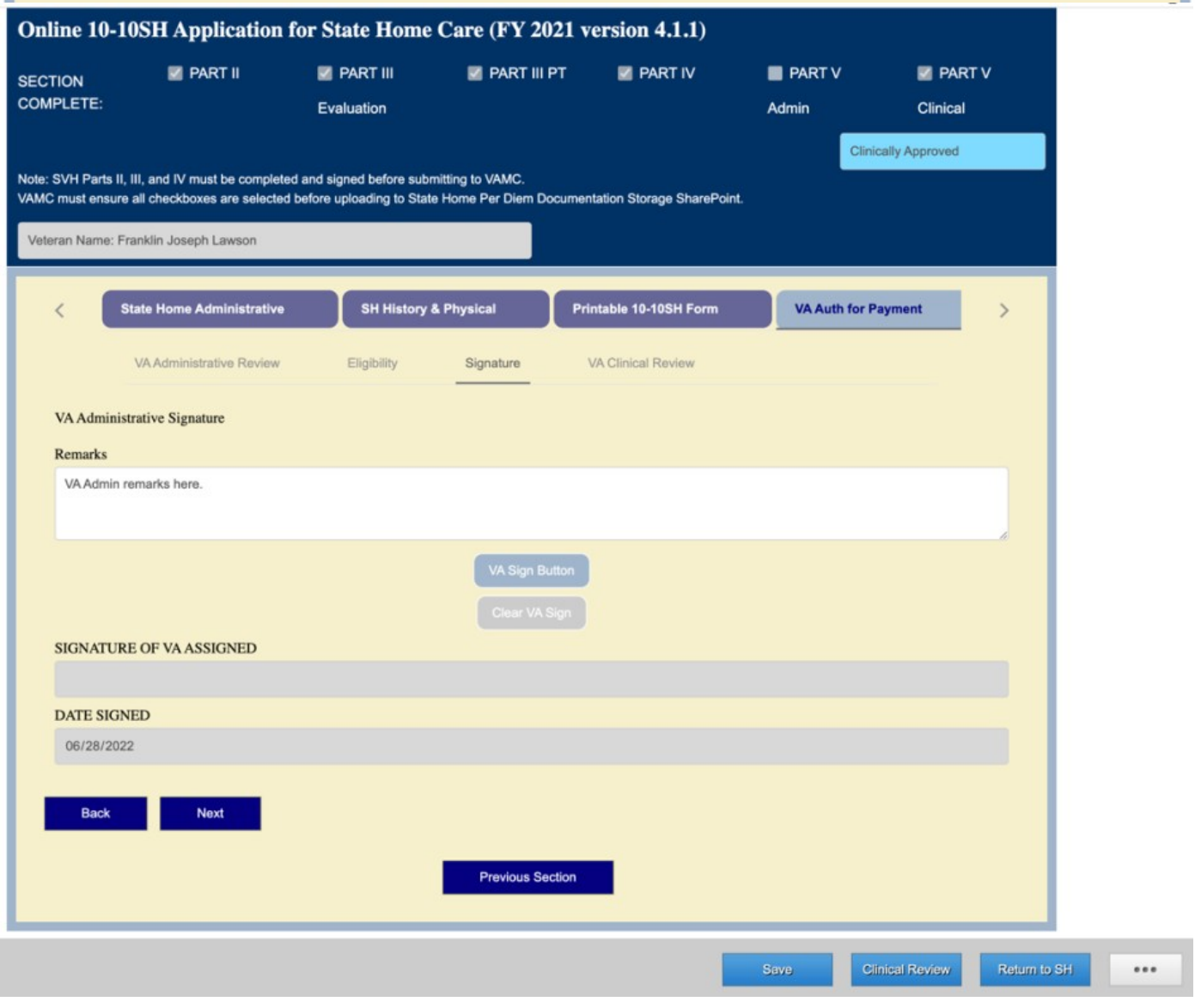

Tracking
Preferences
Help
Logout
physician testdoma...
Details
Form
History
Attachments(0)
Notes(0)
Online 10-10SH Application for State Home Care (FY 2021 version 4.0.1)
SECTION COMPLETE:
PART II
PART III
Evaluation
PART III PT
PART IV
PART V
Admin
PART V
Clinical
No Decision
Note: SVH Parts II, III, 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
Evaluation Screen 1
Evaluation Screen 2
Physical Therapy
Social Work
Remar
Skip to Main Content
REMARKS
Previous Page
Previous Section
Next Section
Save
Return to Clini...
To State Admi...

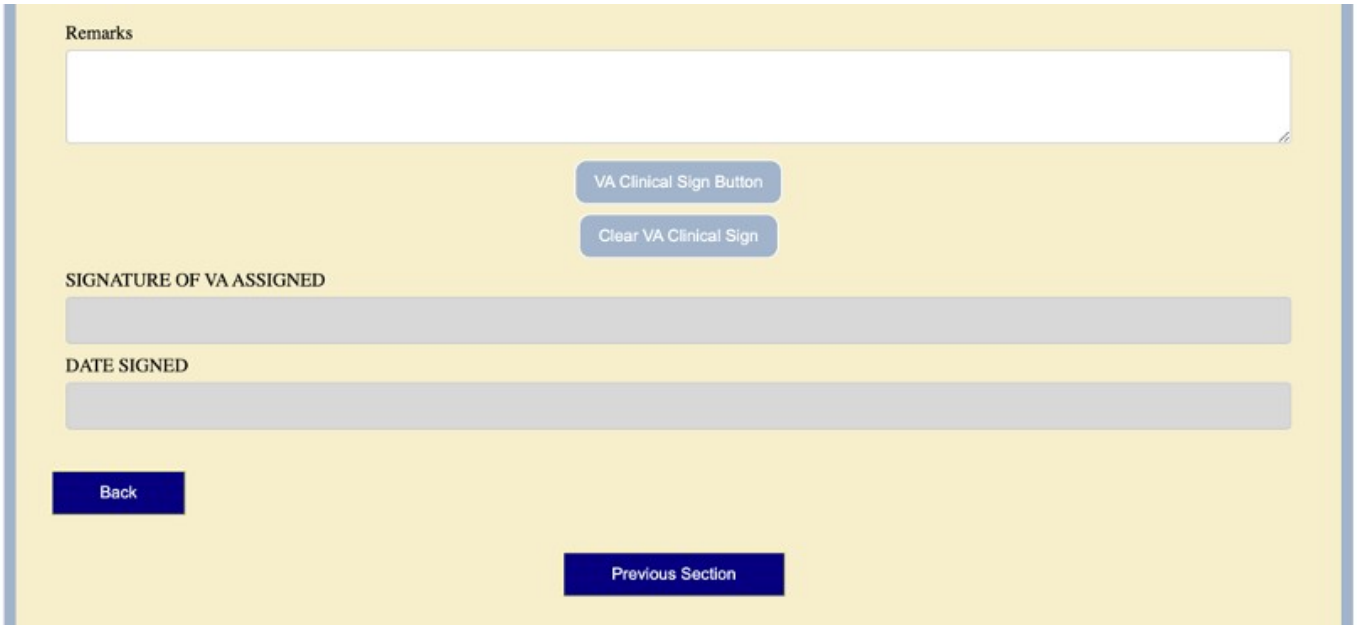
VAMC Workflow:






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 Evaluation
PART III PT
PART IV
PART V Admin
PART V 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
Back
Next
Previous Section
Save
Clinical Review
Return to SH



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	☐ N/A	CBC	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A
	SEROLOGY							☐ N/A
	URINALYSIS	DATE *(MM/DD/YYYY)*	ALBUMIN		ACETONE		SUGAR	☐ 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.