OMB Number: 2900-0629
Estimated Burden: 90 min.
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR EXTENDED CARE SERVICES *(VAF 10-10EC)*

STEP 1. Before You Start. . . .

Enrollment is required to determine copay responsibility. You must complete this form if you are applying for extended care services. If you are currently receiving extended care services and you have a change in marital/dependent status or financials you must submit a new 10-10EC application to your local VA medical facility within 10 calendar days of the change. *Source: Code of Federal Regulations 17.111 Copayments for Extended Care Services.*

What is VA Form 10-10EC used for?

To estimate monthly copayment responsibility for extended care services provided to you by VA, either directly, or paid for by the VA. There is no copayment for the first 21 days of extended care services that VA provides to you in any 12 month period.

Where can I get help understanding how to fill out the form?

Enrolled Veterans may contact your local VA medical facility for assistance on understanding the information and financial data needed to complete VA Form 10-10EC.

What will I need to know in order to complete the form?

Current income of Veteran and spouse *(stated in frequency of receipt, e.g., per week, bi-weekly, twice monthly, monthly, annually).*
Current deductible expenses *(report monthly or annual expenses unless otherwise stated on the application).*
Value of fixed and liquid assets of both Veteran and spouse. See Sections V and VI of these instructions for details.
All health insurance information covering you even if it is through your spouse *(a copy of your insurance card).*
Medicare information *(Part A & Part B) (a copy of your Medicare card).*
Spousal/Dependent information *(including social security number, date of marriage, and date of birth).*

STEP 2. Completing the application . . . .

Section I - General Information. Include your name and full social security number.

Section II - Insurance Information. Include a copy of Medicaid, Medicare and all health insurance cards covering you, including coverage through your spouse. Current insurance may help to reduce your copayment responsibility.

Section III - Spouse/Dependent Information. Required to determine a Veteran's copay responsibility for extended care services. A dependent is a spouse, biological child, adopted child, or stepchild. A spouse/dependent is considered to be "*Non-institutionalized"* when residing in the community with or separate from the Veteran. A spouse/dependent is considered to be "*Institutionalized"* when residing in a nursing home or hospital setting.

For the purpose of this application a Veteran is considered "Single" when widowed, divorced, legally separated, or never married. Legally separated and divorced are recognized when an official court decree/order exists and must be provided upon request. **Do not include spousal information if you and your spouse are legally separated or divorced**. Guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

Report as "Divorced, Legally Separated, or Widowed This Year" if the event happened after January 1st of the current year.

Report as "Single - With Dependents (*Not Institutionalized*) when a dependent child resides in the community and the Veteran is single, divorced, legally separated or widowed.

Report as "Married Living Separate from Spouse (*Institutionalized*)" when spouse resides in a nursing home or hospital setting.

Report as "Married Living Separate from Spouse (*Not-institutionalized*)" when spouse resides in the community.

Section IV - Financial Disclosure. *Select only one checkbox*.

Section V - Fixed Assets. Used in calculation of available resources for monthly copayment when a Veteran reaches 181+ days of institutional *(inpatient)* extended care services.

Report real property minus any outstanding lien or mortgage.

Report combined assets in the Veteran column when living with a spouse who resides in the community *(not institutionalized).*

Report spouse's assets separately when living with a spouse who resides in the community *(not institutionalized).*

Section VI - Liquid Assets. Used in calculation of available resources for monthly copayment when a Veteran reaches 181+ days of institutional *(inpatient)* extended care services. The value of liquid assets will be reduced by a spousal resource protection amount when a spouse is not institutionalized. Spousal resource protection amount does not apply when the spouse is institutionalized in a nursing home or hospital setting. Spousal resource protection amount is updated annually in January.

Report cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirements accounts, art, rare coins, stamp collections, and other collectibles.

Report household and personal items such as furniture, clothing and jewelry when the Veteran has no dependents residing in the community *(not institutionalized)*.

Section VII - Current Gross Income of Veteran and Spouse.

Report wages, bonuses, tips, severance pay and accrued benefits.

Report income from a business *(minus business expenses).*

Report cash gifts, inheritance amounts, interest income, and the standard dividend income from non-tax deferred annuities.

Report retirement income and pension income.

Report unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, and court mandated payments.

Report payments from VA or any other Federal programs, and any other income.

Section VIII. Expenses for Veteran, Spouse, and Dependents *(average monthly unless otherwise stated on the application).*

Report basic subsistence *(living)* expenses.

Report educational expense.

Report funeral or burial expenses, and prepaid funeral or burial arrangements.

Report rent or mortgage payment for primary residence only.

Report utilities *(electricity, gas, water, phone, or internet)* in the past year.

Report car payment for one vehicle.

Report amount spent for food.

Report non-reimbursed medical and dental care, medications, eyeglasses, Medicare, medical insurance premiums, medical copayments and other hospital or nursing home expense.

Report court ordered payments such as alimony or child support.

Report insurance premiums such as automobile and homeowners. Exclude life insurance premiums.

Report taxes paid on property and income over the past 12 months.

STEP 3. Submitting your application

What do I do when I have finished my application?

1. Read Section XI, *Consent for Assignment of Benefits*, Section IX, *Consent to Agreement to Make Copayments*, and Section X, *Privacy Act and Paperwork Reduction Act Information*.
2. In Section XI, you or an individual to whom you have delegated your Power of Attorney must sign and date.
3. Attach copies of Medicare and other health insurance cards, and your Power of Attorney documents to this application.
4. Return the original form and supporting documentation to your local VA medical facility.

STEP 4. Understanding your Estimated VA Extended Care Copayment Amounts.

Based on your marital/dependents status, some income, expenses, and assets might not be used in the calculation of your available resources. After VA Form 10-10EC information is entered into the system, your local VA medical facility will inform you, or an individual to whom you have delegated your Power of Attorney, on your estimated monthly copayment responsibility for extended care services. Administrative staff at your local VA medical facility are available to assist with VA copayment questions.

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Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR EXTENDED CARE SERVICES

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation. (See 18 U.S.C. 287 and 1001)

1. VETERAN'S NAME *(Last, First, MI)*

2. SOCIAL SECURITY NUMBER *(999-99-9999)*

SECTION II - INSURANCE INFORMATION

3. DO YOU HAVE CURRENT INSURANCE?

☐ YES (*If yes, provide a copy of all insurance card(s) covering the Veteran)* ☐ NO

SECTION III - SPOUSE/DEPENDENT INFORMATION

4. CURRENT MARITAL STATUS *(Select only one)* (*Single Includes Widowed, Divorced, Legally Separated, or Never Married)*

☐ Single - With Dependent *(Not Institutionalized)*
☐ Married - Living Separate from Spouse *(Not Institutionalized)*
☐ Married - Living with Spouse *(Not Institutionalized)*
☐ Single - With no dependents residing in the community
☐ Married - Living Separate from Spouse *(Institutionalized)*
☐ Divorced, Legally Separated, or Widowed This Year

5. SPOUSE'S NAME *(Last, First, MI)*	5A. SOCIAL SECURITY NUMBER *(999-99-9999)*	5B. DATE OF BIRTH *(MM/DD/YYYY)*
5C. DATE OF MARRIAGE *(MM/DD/YYYY)*	5D. DATE OF LEGAL SEPARATION OR DIVORCE *(MM/DD/YYYY)*	5E. DATE OF DEATH *(MM/DD/YYYY)*
6. DEPENDENT NAME *(Last, First, MI)*	6A. SOCIAL SECURITY NUMBER *(999-99-9999)*	6B. DATE OF BIRTH *(MM/DD/YYYY)*
7. DEPENDENT NAME *(Last, First, MI)*	7A. SOCIAL SECURITY NUMBER *(999-99-9999)*	7B. DATE OF BIRTH *(MM/DD/YYYY)*
8. DEPENDENT NAME *(Last, First, MI)*	8A. SOCIAL SECURITY NUMBER *(999-99-9999)*	8B. DATE OF BIRTH *(MM/DD/YYYY)*
9. DEPENDENT NAME *(Last, First, MI)*	9A. SOCIAL SECURITY NUMBER *(999-99-9999)*	9B. DATE OF BIRTH *(MM/DD/YYYY)*

SECTION IV - FINANCIAL DISCLOSURE

We need to collect information regarding income, assets and expenses for you and your spouse. If you do not wish to provide this information you must sign agreeing to make copayments and will be charged the maximum copayment amount for all services. *(Select only one checkbox below)*

☐ NO, I am not providing financial details. I understand I will be assessed the maximum copayment amount for extended care services and agree to pay the applicable VA copayment as required by law.

☐ YES, I am providing financial details for the current calendar year.

SECTION V - FIXED ASSETS

(N/A for Non-Institutional care; Only applies to Institutional (Inpatient) Extended Care Services after 181+ days)
(Exclude Spouse's Assets when Legally Separated)

	VETERAN	SPOUSE
1. Primary Residence of Veteran and spouse *(Market value minus mortgages or liens).*		
2. Other Residences/Land/Farm or Ranch *(Market value minus mortgages or liens)* (*Include a second home, vacation home, and/or rental properties).*		
3. Vehicle(s) *(Value minus any outstanding lien).*		

SECTION VI - LIQUID ASSETS

	VETERAN	SPOUSE
1. Cash, Amount in Bank Accounts *(checking and savings accounts, certificates of deposit, individual retirement accounts, stocks, and bonds).*		
2. Other Liquid Assets (*art, rare coins, stamp collections, collectibles* ***minus*** *the amount you owe on these items).*		
3. Household Effects *(clothing, jewelry, and personal items) (Exclude when a spouse or dependent is residing in community (not institutionalized).*		

SECTION VII - CURRENT GROSS INCOME
(Exclude Spouse Income when Legally Separated)

	VETERAN	SPOUSE
1. Gross income from employment *(wages, bonuses, tips, severance pay, and accrued benefits).* *Select only one.* a. How Often? - Veteran: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly b. How Often? - Spouse: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly		
2. Net income from your farm, ranch, property, or business. a. How Often? - Veteran: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly b. How Often? - Spouse: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly		
3. Other income *(social security, retirement, pension, interest, dividends).* a. How Often? - Veteran: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly b. How Often? - Spouse: ☐ Annually ☐ Monthly ☐ Twice Monthly ☐ Bi-Weekly ☐ Weekly		

SECTION VIII - DEDUCTIBLE EXPENSES
(Monthly average over past 12 months unless otherwise stated)
(Exclude Spouse Expenses when Legally Separated)

	AMOUNT
1. Educational expenses for Veteran, spouse or dependent *(tuition, books, fees, material, etc.)*	
2. Funeral and Burial expenses for spouse or child *(including pre-paid arrangements)*	
3. Rent/Mortgage for primary residence How Often? *Select only one.* ☐ Monthly ☐ Annually	
4. Utilities for primary residence	
5. Car Payment for one vehicle	
6. Food for Veteran, spouse, and dependents	
7. Non-reimbursed medical expenses *(copayments for physicians, dentists, medications, Medicare, health insurance, hospital, and nursing home expenses).*	
8. Court-ordered payments *(alimony, child support)*	
9. Insurance *(automobile and homeowners, exclude life insurance)*	
10. Taxes paid *(for personal property, home, automobile, and income)*	

SECTION IX - CONSENT TO AGREEMENT TO MAKE COPAYMENTS

Completion of this form with signature of the Veteran or Veteran's representative is certification that the Veteran/representative has received a copy of the Privacy Act Statement and agrees to make appropriate copayments.

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge, and I agree to make the applicable copayment for extended care services as required by law. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001.

SECTION X - VA BURDEN STATEMENT AND PRIVACY ACT INFORMATION

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0629, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 90 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0629 in any correspondence. Do not send your completed VA Form 10-10EC to this email address.

PRIVACY ACT INFORMATION: The VA is asking you to provide the information on this form under Title 38 U.S.C. sections 1710, 1712, 1722 and 1729 for VA to determine your eligibility for extended care benefits and to establish financial eligibility, if applicable, when placed in extended care services. Obligation to respond is voluntary. The information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law; possible disclosures include those described in the "routine use" 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. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA with your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

SECTION XI - CONSENT FOR ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

SIGNATURE *(Sign in ink)*	DATE *(MM/DD/YYYY)*
VETERAN'S NAME *(Last, First, MI)*	SOCIAL SECURITY NUMBER *(999-99-9999)*