AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

(i) Participants will be transferred from the adult day health care program to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by a physician; and

(ii) Medical and other information needed for care and treatment of participants will be exchanged between the institutions.

(2) The transfer must be with a hospital sufficiently close to the adult day health care program to make transfer feasible.

(q) *Compliance with Federal, State, and local laws and professional standards.* The program management must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This includes the Single Audit Act of 1984 (31 U.S.C. 7501 et seq.) and the Cash Management Improvement Acts of 1990 and 1992 (31 U.S.C. 3335, 3718, 3720A, 6501, 6503).

(r) *Relationship to other Federal regulations.* In addition to compliance with the regulations set forth in this subpart, the program must meet the applicable provisions of other Federal laws and regulations, including but not limited to, those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, or age (38 CFR part 18); protection of human subjects of research (45 CFR part 46), section 504 of the Rehabilitation Act of 1993 (29 U.S.C. 794); Drug-Free Workplace Act of 1988 (41 U.S.C. 701–707); restrictions regarding lobbying (31 U.S.C. 1352); Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d–1). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(s) *Intermingling.* A facility recognized as a State home for providing adult day health care may only provide adult day health care in the areas of the facility recognized as a State home for providing adult day health care.

(t) *VA management of State veterans homes.* Except as specifically provided by statute or regulations, VA employees have no authority regarding the management or control of State homes providing adult day health care.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this paragraph under control number 2900–0160)

§ 52.220 Transportation.

Transportation of participants to and from the adult day health care facility must be a component of the overall program.

(a)(1) Except as provided in paragraph (a)(2) of this section, the adult day health care program management must provide or contract for transportation to enable participants, including persons with disabilities, to attend the program and to participate in facility-sponsored outings.

(2) The veteran or the family of a veteran may decline transportation offered by the adult day health care program management and make their own arrangements for the transportation.

(b) The adult day health care program management must have a transportation policy that includes routine and emergency procedures, with a copy of the relevant procedures located in all program vehicles.

(c) All vehicles transporting participants to and from adult day health care must be equipped with a device for two-way communication.

(d) All facility-provided and contracted transportation systems must meet local, State and federal regulations.

(e) The time to transport participant to or from the facility must not be more than 60 minutes except under unusual conditions, e.g., bad weather.

(Authority: 38 U.S.C. 101, 501, 1741–1743)

PART 58—FORMS

Sec.

58.10 VA Form 10–3567—State Home Inspection: Staffing Profile.
58.11 VA Form 10–5588—State Home Report and Statement of Federal Aid Claimed.
58.12 VA Form 10–10EZ—Application for Health Benefits.

58.13 VA Form 10–10SH—State Home Program Application for Veteran Care—Medical Certification.
58.14 VA Form 10–0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.
58.15 VA Form 10–0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.
58.16 VA Form 10–0144—Certification Regarding Lobbying.
58.17 VA Form 10–0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

AUTHORITY: 38 U.S.C. 101, 501, 1710, 1741–1743.

SOURCE: 65 FR 981, Jan. 6, 2000, unless otherwise noted.

§ 58.10 VA Form 10–3567—State Home Inspection Staffing Profile.

OMB Approved No. 2900-0160
Estimated Burden Avg. 20 min.

Department of Veterans Affairs

STATE HOME INSPECTION

NAME OF HOME	DATE OF INSPECTION

PART I	TOTAL FACILITY	HOSPITAL	NHC	DOM
OPERATING BEDS				
AUTHORIZED APPROVALS				
PATIENT CENSUS				
POSITIONS AUTHORIZED				
STAFF AVAILABLE				
PART II - STAFF	**TOTAL FACILITY**	**HOSPITAL**	**NHC**	**DOM**
PHYSICIANS:				
PHYSICIANS ASSISTANTS				
DENTISTS				
SOCIAL WORK: MSW				
BSW				
SOCIAL WORK ASSISTANT				
PHARMACY: REG. PHARMACIST				
DIETETICS: REG. DIETITIAN				
FOOD SUPERVISOR				
DIETARY ASSISTANTS				
NURSING:				
NURSING ADM./SUP.				
DIRECT CARE: CERT. N.P./C.N.S.				
R.N.				
L.P.N./L.V.N.				
N.A.				
REHABILITATION THERAPY				
REG. P.T./P.T. AIDES				
REG. O.T./O.T. AIDES				
MENTAL HEALTH: PSYCHOLOGIST				
PSYCHIATRIST				
PSYCHIATRIC SOCIAL WORKER				
COUNSELOR				
SPEECH AND AUDIOLOGY				
OPHTHALMOLOGY/OPTOMETRY				
PODIATRY				
RADIOLOGY/LABORATORY				
RECREATION/ACTIVITIES				
DIRECTOR				
ASSISTANTS				
VOLUNTEERS				
CHAPLAIN				
ADMINISTRATION				
ENGINEERING				
MAINTENANCE/HOUSEKEEPING				
MEDICAL RECORDS				
OTHER *(Specify)*				

VA FORM MAY 1998 (RS) **10-3567** **SEE REVERSE**

NAME OF HOME	DATE OF INSPECTION

NURSING SERVICE STAFFING PATTERN

(Four Week Average)

PART III HOSPITAL *(Average hours Hosp. _____)*

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

PART IV NURSING HOME *(Average hours NHC _____)*

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

PART V DOMICILIARY *(Average hours Dom. _____)*

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																					
EVENING																					
NIGHT																					

VA FORM MAY 1998 (RS) **10-3567** PAGE 2

NAME OF HOME	DATE OF INSPECTION

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 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

VA FORM MAY 1998 (RS) **10-3567** **PAGE 3**

§58.11 VA Form 10–5588—State Home Report and Statement of Federal Aid Claimed.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

TO	VA FACILITY	FROM	NAME AND ADDRESS OF STATE HOME

PAY TO	FOR MONTH ENDING

LINE NO.	ITEM		DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
1	TOTAL VETERAN RESIDENTS REMAINING AT END OF PRIOR MONTH					
2	GAINS	ADMISSIONS *(Change of status)*				
3	GAINS	ADMISSIONS *(Other)*				
4	GAINS	RETURNS FROM LEAVE OF ABSENCE OF MORE THAN 96 HOURS				
5	LOSSES	DISCHARGES *(Change of status)*				
6	LOSSES	DISCHARGES *(Other)*				
7	LOSSES	DEATHS				
8	LOSSES	LEAVES OF ABSENCE OF MORE THAN 96 HOURS				
9	TOTAL VETERAN RESIDENTS REMAINING AT END OF THE MONTH					
10	TOTAL VETERAN DAYS OF CARE FURNISHED					
11	FEMALE VETERAN RESIDENTS REMAINING AT END OF THE MONTH					
12	**NON-VETERAN** RESIDENTS REMAINING AT END OF THE MONTH					

MONTHLY STATEMENT OF ACCOUNT

LINE NO.	FEDERAL AID CLAIMED UNDER SEC.1741, TITLE 38, U.S.C., AS AMENDED	DAYS OF CARE (J)	AVERAGE DAILY CENSUS (K)	TOTAL PER DIEM COST (L)	PER DIEM CLAIMED (M)	TOTAL AMOUNT CLAIMED (N)
13	DOMICILIARY CARE			$	$	$
14	NURSING HOME CARE			$	$	$
15	HOSPITAL CARE			$	$	$
16	ADULT DAY HEALTH CARE			$	$	$
17	**TOTAL AMOUNT CLAIMED**					$

FOR DEPARTMENT OF VETERANS AFFAIR USE ONLY

RECEIVING REPORT - Services authorized under provisions of Sec. 1741, 1742 and 1743, Title 38, U.S.C., have been rendered in the quantity claimed and payment is recommended except as follows:

SIGNATURE AND TITLE OF STATE HOME COORDINATOR	DATE

ACCOUNTING CERTIFICATION - AUDIT BLOCK

AMOUNT DUE	DATE	VOUCHER AUDITOR

VA FORM SEP 1998 (RS) **10-5588** PAGE 1

Department of Veterans Affairs

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

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 of 96 hours or less, and that facility management has complied with all provisions of Title VI, Public Law 88-352, entitled Civil Rights Act of

TOTAL STATE OPERATING BEDS AT END OF THE MONTH

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

BED CAPACITY APPROVED BY VA

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

SIGNATURE OF STATE HOME ADMINISTRATOR	DATE

SIGNATURE OF STATE EMPLOYEE WHEN APPLICABLE	DATE

REMARKS

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 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

VA FORM SEP 1998 (RS) **10-5588** PAGE 2

§58.12 VA Form 10–10EZ—Application for Health Benefits

OMB Approved No. 2900-0091
Estimated Burden Avg. 20 min

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*
☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

2. VETERAN'S NAME *(Last, First, MI)* | 3. OTHER NAMES USED | 4. GENDER *(Check one)* ☐ M ☐ F

5. SOCIAL SECURITY NUMBER | 6. CLAIM NUMBER | 7. DATE OF BIRTH *(mm.dd.yyyy)* | 8. RELIGION

9A. CURRENT MAILING ADDRESS *(Street)* | 9B. CITY | 9C. STATE | 9D. ZIP

9E. COUNTY | 10. HOME TELEPHONE NUMBER ( ) | 11. WORK TELEPHONE NUMBER ( )

12. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

13A. LAST BRANCH OF SERVICE | 13B. LAST ENTRY DATE | 13C. LAST DISCHARGE DATE | 13D. DISCHARGE TYPE | 13E. MILITARY SERVICE NUMBER

14. CIRCLE YES OR NO

A. ARE YOU A FORMER PRISONER OF WAR	YES	NO	H. DO YOU HAVE A MILITARY DENTAL INJURY	YES	NO
B. DO YOU HAVE A VA SERVICE-CONNECTED RATING	YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	YES	NO
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE		%	J. ARE YOU ELIGIBLE FOR MEDICAID	YES	NO
C. ARE YOU RECEIVING A VA PENSION	YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A	YES	NO
D. ARE YOU RETIRED FROM THE MILITARY	YES	NO	K1. EFFECTIVE DATE		
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY	YES	NO	L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B	YES	NO
D2. WERE YOU REGULARLY RETIRED - (20 + yrs.)	YES	NO	L1. EFFECTIVE DATE		
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR	YES	NO	M. MEDICARE CLAIM NUMBER		
F. WERE YOU EXPOSED TO AGENT ORANGE	YES	NO	N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		
G. WERE YOU EXPOSED TO RADIATION	YES	NO			

15A. VETERAN'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED
If employed or retired, complete item 15B / / *Date of retirement*
15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

16A. SPOUSE'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED
If employed or retired, complete item 16B / / *Date of retirement*
16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

17A. VETERAN'S HEALTH INSURANCE COMPANY | 18A. SPOUSE'S HEALTH INSURANCE COMPANY

17B. NAME OF POLICY HOLDER | 18B. NAME OF POLICY HOLDER

17C. POLICY NUMBER | 17D. GROUP CODE | 18C. POLICY NUMBER | 18D. GROUP CODE

19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN | 19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( ) | 19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( )

20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT | 20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( ) | 20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( )

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***
☐ EMERGENCY CONTACT ☐ NEXT OF KIN

22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)* ☐ YES ☐ NO
22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)* ☐ YES ☐ NO

VA FORM APR. 1998 **10-10EZ** PAGE 1

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME	SOCIAL SECURITY NUMBER

SECTION II - FINANCIAL ASSESSMENT

IIA - DEPENDENT INFORMATION ***(Use a separate sheet for additional dependents)***

1. SPOUSE'S NAME *(Last, First, MI)*	2. CHILD'S NAME *(Last, First, MI)*	
3. SPOUSE'S SOCIAL SECURITY NUMBER	4. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	5. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
6. SPOUSE'S ADDRESS *(Street, City, State, ZIP)*	7. CHILD'S SOCIAL SECURITY NUMBER	
8. SPOUSE'S TELEPHONE NUMBER	9. CHILD'S RELATIONSHIP TO YOU *(Circle one)* *Son* *Daughter* *Stepson* *Stepdaughter*	
10. DATE OF MARRIAGE *(mm/dd/yyyy)*	11. DATE CHILD BECAME YOUR DEPENDENT	
12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $	13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(tuition, books, materials, etc.)* $	
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO	15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	

IIB - FINANCIAL DISCLOSURE

You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.

☐ **YES,** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. *Complete all sections below that apply to you with last calendar year's information. Sign and date the application.*

☐ **NO,** I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. *I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.*

IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

	VETERAN	SPOUSE	CHILDREN
1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)*, AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. LIST OTHER INCOME AMOUNTS *(Social Security, compensation, pension, interest, dividends). Exclude welfare.*	$	$	$
3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS *(If yes, refer to page 2, Section IIC of the instructions.)* ☐ YES ☐ NO			

IID - DEDUCTIBLE EXPENSES

1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section IIA)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

IIE - NET WORTH

	VETERAN	SPOUSE
1. CASH, AMOUNT IN BANK ACCOUNTS *(Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)*	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *Do not count your primary home. Include value of farm, ranch, or business assets.*	$	$
3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS *(art, rare coins, etc.)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$	$

SECTION III - CONSENT AND SIGNATURE

CO-PAYMENT NOTICE: If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) **and** your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.

I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.	DATE *(mm/dd/yyyy)*
SIGN HERE *(Signature of applicant or applicant's representative)*	

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.

VA FORM APR. 1998 **10-10EZ** **PAGE 2**

§58.13 VA Form 10–10SH—State Home Program Application for Veteran Care Medical Certification.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER M F
RESIDENT'S NAME (*Last, First, Middle*)	SOCIAL SECURITY NUMBER	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE NO YES	

PART II - HISTORY AND PHYSICAL ***(Use separate sheet if necessary)***

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT

NECK	CARDIOPULMONARY
ABDOMEN	GENITOURINARY
RECTAL	EXTREMITIES
NEUROLOGICAL	ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB	CHEST X-RAY	DATE:	RESULTS	CBC	DATE:	RESULTS
	SEROLOGY					
	URINALYSIS	DATE	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CIRCLE NA

IS DEMENTIA THE PRIMARY DIAGNOSIS	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
YES NO	YES NO	YES NO	YES NO

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

OXYGEN		TUBE FEEDING	DECUBITUS ULCERS	FOLEY CATHETER
MASK	PRN	OSTOMY	DRAINING WOUND	TEMPORARY
NASAL CANULAR	CONTINUOUS	TRACHOSTOMY	WOUND CULTURED	PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

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

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

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

VA FORM JUL 1998 **10-10SH** **PAGE 1**

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED

RESIDENT'S NAME (*Last, First, Middle*)	SOCIAL SECURITY NUMBER

EVALUATION (Circle appropriate number in each category)

COMMUNICATION	1. Transmits messages/receives information 2. Limited ability 3. Nearly or totally unable	**SPEECH**	1. Speaks clearly with others of same language 2. Limited ability 3. Unable to speak clearly or not at all
HEARING	1. Good 2. Hearing slightly impaired. 3. Limited hearing (e.g.- must speak loudly) 4. Virtually/completely deaf	**SIGHT**	1. Good 2. Vision adequate - Unable to read/see details 3. Vision limited - Gross object differentiation 4. Blind
TRANSFER	1. No assistance 2. Equipment only 3. Supervision only 4. Requires human transfer w/wo equipment 5. Bedfast	**AMBULATION**	1. Independence w/wo assistive device 2. Walks with supervision 3. Walks with continuous human support 4. Bed to chair (total help) 5. Bedfast
ENDURANCE	1. Tolerates distances (250 feet sustained activity) 2. Needs intermittent rest 3. Rarely tolerates short activities 4. No tolerance	**MENTAL AND BEHAVIOR STATUS**	1. Alert 2. Confused 3. Disoriented 4. Comatose 5. Agreeable 6. Disruptive 7. Apathetic 8. Well motivated
TIOLETING	1. No assistance 2. Assistance to and from and transfer 3. Total assistance including personal hygiene, help with clothes A. Bathroom B. Bedside commode C. Bedpan	**BATHING**	1. No assistance 2. Supervision only 3. Assistance 4. Is bathed A. Tub B. Shower C. Sponge bath
DRESSING	1. Dresses self 2. Minor assistance 3. Needs help to complete dressing 4. Has to be dressed	**FEEDING**	1. No assistance 2. Minor assistance, needs tray set up only 3. Help feeding/encouraging 4. Is fed
BLADDER CONTROL	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Catheter, indwelling	**BOWEL CONTROL**	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent, - up to once a day 5. Total incontinence 6. Ostomy
SKIN CONDITION	1. Intact 2. Dry/Fragile 3. Irritations (Rash) 4. Open wound 5. Decubitus Number _____ Stage _____	**WHEEL CHAIR USE**	1. Independence 2. Assistance in difficult maneuvering 3. Wheels a few feet 4. Unable to use ☐ **NA**

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN	DATE

PHYSICAL THERAPY ***(To be completed by Physical Therapist or Referring Physician*** ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY

SENSATION IMPAIRED	RESTRICT ACTIVITY	PRECAUTIONS	FREQUENCY OF TREATMENT
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ CARDIAC ☐ (OTHER *Specify*)	

TREATMENT GOALS:

☐ STRETCHING	☐ ACTIVE	☐ COORDINATING ACTIVITIES	☐ FULL WEIGHT BEARING	☐ WHEELCHAIR INDEPENDENT
☐ PASSIVE ROM	☐ ACTIVE ASSISTIVE	☐ NON-WEIGHT BEARING	☐ PROGRESS BED TO WHEELCHAIR	☐ COMPLETE AMBULATION
	☐ PROGRESSIVE RESISTIVE	☐ PARTIAL WEIGHT BEARING	☐ RECOVERY TO FULL FUNCTION	

ADDITIONAL THERAPIES	SIGNATURE OF AND TITLE OF THERAPIST	DATE
☐ **O.T.** ☐ **SPEECH** ☐ **DIETARY**		

SOCIAL WORK ASSESSMENT ***(To be completed by Social Worker)***

PRIOR LIVING ARRANGEMENTS	LONG RANGE PLAN	
ADJUSTMENT TO ILLNESS OR DISABILITY	SIGNATURE OF SOCIAL WORKER	DATE

VA AUTHORIZATION FOR PAYMENT

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT	LEVEL OF CARE RECOMMENDED	
	☐ APPROVED ☐ DISAPPROVED	☐ NHC ☐ DOMICILIARY ☐ HOSPITAL ☐ ADHC	
REASON FOR DISAPPROVAL		☐ APPROVED ☐ DISAPPROVED	REASON FOR DISAPPROVAL
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

VA FORM JUL 1998 **10-10SH** **PAGE 2**

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

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 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742 and 1743. 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.

VA FORM JUL 1998 **10-10SH**

§ 58.14 VA Form 10–0143A—Statement of Assurance of Compliance with Section 504 of The Rehabilitation Act of 1973.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973

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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

_____(hereinafter called the "Signatory")
(Name and location of State Veterans Home)

HEREBY AGREES THAT

It will comply with section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112) and all regulations adopted pursuant to such section, for instance, VA Regulations 7800 Series (38 CFR Section 18), to the end that no person in the United States shall, on the ground of handicap, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statues administered by the VA; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate the agreement.

If any real property or structure thereon is provided or improved with the aid of the Federal financial assistance extended to the Signatory by the VA, this assurance shall obligate the Signatory, or in the case of transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by the VA.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under Section 1741 of Title 38 USC. Federal financial assistance is understood to include benefits paid directly to the Signatory, and/or benefits paid to a beneficiary contingent upon such beneficiary being enrolled in a program offered by the Signatory.

The Signatory recognizes and agrees that such Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance, and that the VA will withhold financial assistance, facilities, or other benefits to ensure fulfillment of this assurance of compliance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Signatory, its successors, transferees, and assignees. The person or persons whose signatures appear below are authorized to sign this assurance.

SIGNATURE OF AUTHORIZED OFFICIAL	
TITLE	DATE
MAILING ADDRESS	

VA FORM SEP1998 (R) **10-0143A** **REPRODUCE LOCALLY** JetForm

§58.15 VA Form 10–0143—Department of Veterans Affairs Certification Regarding Drug-Free Workplace Requirements for Grantees Other Than Individuals.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988, 38 CFR 44, Subpart F. The regulations, published in the January 31, 1989, Federal Register (pages 4950-4952) require certification by grantees, prior to award, that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the agency determines to award the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government-wide suspension or debarment (see CFR Part 44, Section 44.100 through 44.420).

The grantee certifies that it will provide a drug-free workplace by:

(1) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(2) Establishing a drug-free awareness program to inform employees about

(a) The dangers of drug abuse in the workplace;
(b) The grantee's policy of maintaining a drug-free workplace;
(c) Any available drug counseling, rehabilitation, and employee assistance programs; and
(d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(3) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (1);

(4) Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will

(a) Abide by the terms of the statement; and
(b) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(5) Notifying the agency within ten days after receiving notice under subparagraph (4) (b) from an employee or otherwise receiving actual notice of such convictions;

(6) Taking one of the following actions, within 30 days of receiving notice under subparagraph (4) (b), with respect to any employee who is so convicted;

(a) Taking appropriate personnel action against such employee, up to and including termination; or
(b) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(7) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (1), (2), (3), (4), (5) and (6).

VA FORM SEP1998 (R) **10-0143** **REPRODUCE LOCALLY** JetForm

OMB Number: 2900-0188
Estimated Burden: 15 minutes

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEES OTHER THAN INDIVIDUALS

Places of Performance: The grantee shall insert in the space provided below the site(s) for performance of work done in connection with the specific grant (street address, city, county, state, zip code)

ORGANIZATION NAME	GRANT NUMBER OR NAME
NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE

VA FORM SEP1998 (R) **10-0143** **REPRODUCE LOCALLY** JetForm

§58.16 VA Form 10–0144—Certification Regarding Lobbying.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

CERTIFICATION REGARDING LOBBYING

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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

This certification is made in compliance with Section 319 of Public Law 101-121; and pursuant to the Interim Final guidance published as part VII of the December 20, 1989, Federal Register (Pages 57306-52332).

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certified, to the best of their knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Forms-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31 U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE OF CERTIFYING OFFICIAL	DATE
NAME AND TITLE OF CERTIFYING OFFICIAL	PROJECT (FAI NUMBER)
NAME AND ADDRESS OF STATE AGENCY	

VA FORM SEP1999 (R) **10-0144** **REPRODUCE LOCALLY**

§ 58.17 VA Form 10–0144A—Statement of Assurance of Compliance with Equal Opportunity Laws.

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

STATEMENT OF ASSURANCE OF COMPLIANCE WITH EQUAL OPPORTUNITY LAWS

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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

_____(hereinafter called the"Signatory")
(Name of Organization, Institution, or Individual)

HEREBY AGREES THAT:

It will comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), and all Federal regulations adopted to carry out such laws. This assurance is directed to the end that no person in the United States shall, on the ground of race, color, national origin (Title VI), handicap (Section 504), sex (Title IX, in education programs and activities only), or age (Age Discrimination Act) be excluded from participation in , be denied the benefits of, or be subjected to discrimination under any program or activity of the Signatory receiving Federal financial assistance or other benefits under statutes administered by VA (Department of Veteran Affairs), the ED (Department of Education), or any other Federal agency. This assurance applies whether assistance is given directly to the recipient or indirectly through benefits paid to a student, trainee, or other beneficiary because of enrollment or participation in a program of the Signatory.

The Signatory HEREBY GIVES ASSURANCE that it will promptly take measures to effect this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Signatory or ED, this assurance-shall obligate the Signatory, or in the case of transfer of such property any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. In all cases, this assurance shall obligate the Signatory for the period during which the Federal financial assistance is extended to any of its programs by VA, ED or any other Federal agency.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining Federal financial assistance, including facilities furnished or payments made under sections 104 and 244(1) of Title 38, U.S.C. Also, sections 1713, 1720, 1720A, 1741-1743, 2408, 5902(a)(2), 8131-8137, 8151-8156 (formerly 613, 620, 620A, 641-643, 1008, 3402(a)(2), 5031-5037, 5051-5056 respectively) and 38 U.S.C. chapters 30, 31, 32, 35, 36, 82, and 10 U.S.C. chapter 106. Under the terms of an agreement between VA and ED, this assurance also includes Federal financial assistance given by ED through programs administered by that agency. Federal financial assistance is understood to include benefits paid directly to the Signatory and/or benefits paid to a beneficiary contingent upon the beneficiary's enrollment in a program or using services offered by the Signatory.

The Signatory agrees that Federal financial assistance or other benefits will be extended in reliance on the representations and agreements made in this assurance; that VA or ED will withhold financial assistance, facilities, or other benefits to assure compliance with the equal opportunity laws; and that the United States shall have the right to seek judicial enforcement of this assurance.

THIS ASSURANCE is binding on the Signatory, its successors, transferees, and assignees for the period during which assistance is provided. The Signatory assures that all contractors, subcontractors, subgrantees, or others with whom it arranges to provide services or benefits to its students or trainees in connection with the Signatory's programs or services are not discriminating against those students or trainees in violation of the above statutes.

SIGNATURE OF AUTHORIZED OFFICIAL	DATE
NAME AND TITLE OF AUTHORIZED OFFICIAL	
MAILING ADDRESS OF AUTHORIZED OFFICIAL	

VA FORM APR 1999 (R) **10-0144A**