

**§ 52.220**

**38 CFR Ch. I (7-1-08 Edition)**

(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 non-discrimination 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.

**Department of Veterans Affairs**

**Pt. 58**

- 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

38 CFR Ch. I (7-1-08 Edition)

§ 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
<b>PART I</b>	<b>TOTAL FACILITY</b>	<b>HOSPITAL</b>	<b>NHC</b>	<b>DOM</b>	
OPERATING BEDS					
AUTHORIZED APPROVALS					
PATIENT CENSUS					
POSITIONS AUTHORIZED					
STAFF AVAILABLE					
<b>PART II - STAFF</b>	<b>TOTAL FACILITY</b>	<b>HOSPITAL</b>	<b>NHC</b>	<b>DOM</b>	
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 10-3567  
MAY 1998 (RS)

SEE REVERSE

NAME OF HOME	DATE OF INSPECTION
--------------	--------------------

**NURSING SERVICE STAFFING PATTERN**  
*(Four Week Average)*

		PART III HOSPITAL (Average hours Hosp. _____)																				
		SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
SHIFT		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 _____)																				
		SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
SHIFT		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. _____)																				
		SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
SHIFT		RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA	RN	LPN	NA
DAY																						
EVENING																						
NIGHT																						

NAME OF HOME	DATE OF INSPECTION
<p><b>The Paperwork Reduction Act of 1995</b> 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.</p>	

§ 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		ADMISSIONS (Other)				
4		RETURNS FROM LEAVE OF ABSENCE OF MORE THAN 96 HOURS				
5	LOSSES	DISCHARGES (Change of status)				
6		DISCHARGES (Other)				
7		DEATHS				
8		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		

 Department of Veterans Affairs			
<b>STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED</b>			
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			
<b>TOTAL STATE OPERATING BEDS AT END OF THE MONTH</b>			
DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE
<b>BED CAPACITY APPROVED BY VA</b>			
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			
<p><b>The Paperwork Reduction Act of 1995</b> 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.</p>			

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

OMB Approved No. 2900-0097  
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)					
<input type="checkbox"/> HEALTH SERVICES		<input type="checkbox"/> NURSING HOME		<input type="checkbox"/> DOMICILIARY	
				<input type="checkbox"/> DENTAL	
				<input type="checkbox"/> 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)
					<input type="checkbox"/> M <input type="checkbox"/> 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)					
<input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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)			<input type="checkbox"/> NOT EMPLOYED	15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
If employed or retired, complete item 15B			<input type="checkbox"/> EMPLOYED		
			<input type="checkbox"/> RETIRED	Date of retirement	
16A. SPOUSE'S EMPLOYMENT STATUS (check one)			<input type="checkbox"/> NOT EMPLOYED	16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
If employed or retired, complete item 16B			<input type="checkbox"/> EMPLOYED		
			<input type="checkbox"/> RETIRED	Date of retirement	
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.)					
<input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN					
22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY (Check one)			22B. IS NEED FOR CARE DUE TO ACCIDENT (Check one)		
<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		

<b>APPLICATION FOR HEALTH BENEFITS, Continued</b>		VETERAN'S NAME	SOCIAL SECURITY NUMBER
<b>SECTION II - FINANCIAL ASSESSMENT</b>			
<b>IIA - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)</b>			
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 YOU FOR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (tuition, books, materials, etc.) \$	
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>IIB - FINANCIAL DISCLOSURE</b>			
<p>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.</p> <p><input type="checkbox"/> <b>YES</b>, 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.</p> <p><input type="checkbox"/> <b>NO</b>, 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.</p>			
<b>IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN</b>			
	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) <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>IID - DEDUCTIBLE EXPENSES</b>			
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.		\$	
<b>IIE - NET WORTH</b>			
	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.	\$	\$	
<b>SECTION III - CONSENT AND SIGNATURE</b>			
<b>CO-PAYMENT NOTICE:</b> 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)	
<b>SIGN HERE</b>  (Signature of applicant or applicant's representative)			
<b>THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.</b>			

§ 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					
<b>PART I - ADMINISTRATIVE</b>							
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			
<b>PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)</b>							
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		
<b>CHECK ALL BOXES THAT APPLY OR CIRCLE NA</b>							
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	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			
<b>TYPE OF CARE RECOMMENDED:</b> 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			

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED			
RESIDENT'S NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	
<b>EVALUATION (Circle appropriate number in each category)</b>			
<b>COMMUNICATION</b>	1. Transmits messages/receives information 2. Limited ability 3. Nearly or totally unable	<b>SPEECH</b>	1. Speaks clearly with others of same language 2. Limited ability 3. Unable to speak clearly or not at all
<b>HEARING</b>	1. Good 2. Hearing slightly impaired. 3. Limited hearing (e.g. - must speak loudly) 4. Virtually/completely deaf	<b>SIGHT</b>	1. Good 2. Vision adequate - Unable to read/see details 3. Vision limited - Gross object differentiation 4. Blind
<b>TRANSFER</b>	1. No assistance 2. Equipment only 3. Supervision only 4. Requires human transfer w/wo equipment 5. Bedfast	<b>AMBULATION</b>	1. Independence w/wo assistive device 2. Walks with supervision 3. Walks with continuous human support 4. Bed to chair (total help) 5. Bedfast
<b>ENDURANCE</b>	1. Tolerates distances (250 feet sustained activity) 2. Needs intermittent rest 3. Rarely tolerates short activities 4. No tolerance	<b>MENTAL AND BEHAVIOR STATUS</b>	1. Alert 2. Confused 3. Disoriented 4. Comatose 5. Agreeable 6. Disruptive 7. Apathetic 8. Well motivated
<b>TOILETING</b>	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	<b>BATHING</b>	1. No assistance 2. Supervision only 3. Assistance 4. Is bathed A. Tub B. Shower C. Sponge bath
<b>DRESSING</b>	1. Dresses self 2. Minor assistance 3. Needs help to complete dressing 4. Has to be dressed	<b>FEEDING</b>	1. No assistance 2. Minor assistance, needs tray set up only 3. Help feeding/encouraging 4. Is fed
<b>BLADDER CONTROL</b>	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent - up to once a day 5. Total incontinence 6. Catheter, indwelling	<b>BOWEL CONTROL</b>	1. Continent 2. Rarely incontinent 3. Occasional - once/week or less 4. Frequent, - up to once a day 5. Total incontinence 6. Ostomy
<b>SKIN CONDITION</b>	1. Intact 2. Dry/Fragile 3. Irritations (Rash) 4. Open wound 5. Decubitus Number _____ Stage _____	<b>WHEEL CHAIR USE</b>	1. Independence 2. Assistance in difficult maneuvering 3. Wheels a few feet 4. Unable to use <input type="checkbox"/> NA
SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN			DATE
<b>PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician)</b> <input type="checkbox"/> NEW REFERRAL <input type="checkbox"/> CONTINUATION OF THERAPY			
SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> (OTHER Specify)	FREQUENCY OF TREATMENT
<b>TREATMENT GOALS:</b> <input type="checkbox"/> STRETCHING <input type="checkbox"/> PASSIVE ROM	<input type="checkbox"/> ACTIVE <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> PROGRESSIVE RESISTIVE	<input type="checkbox"/> COORDINATING ACTIVITIES <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PARTIAL WEIGHT BEARING	<input type="checkbox"/> FULL WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> RECOVERY TO FULL FUNCTION
<b>ADDITIONAL THERAPIES</b> <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY	SIGNATURE OF AND TITLE OF THERAPIST		DATE
<b>SOCIAL WORK ASSESSMENT (To be completed by Social Worker)</b>			
PRIOR LIVING ARRANGEMENTS		LONG RANGE PLAN	
ADJUSTMENT TO ILLNESS OR DISABILITY		SIGNATURE OF SOCIAL WORKER	DATE
<b>VA AUTHORIZATION FOR PAYMENT</b>			
DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	LEVEL OF CARE RECOMMENDED <input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC	
REASON FOR DISAPPROVAL	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	REASON FOR DISAPPROVAL	
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN	DATE

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

<b>PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE</b>	
<p><b>The Paperwork Reduction Act of 1995</b> 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.</p>	
<p><b>Privacy Act Information</b> 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.</p>	

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	
<b>STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973</b>	
<p>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.</p>	
_____ (hereinafter called the "Signatory")	
(Name and location of State Veterans Home)	
<p><b>HEREBY AGREES THAT</b></p> <p>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 statutes administered by the VA; and <b>HEREBY GIVES ASSURANCE THAT</b> it will immediately take any measures necessary to effectuate the agreement.</p> <p>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.</p> <p><b>THIS ASSURANCE</b> 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.</p> <p>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.</p>	
SIGNATURE OF AUTHORIZED OFFICIAL	
TITLE	DATE
MAILING ADDRESS	

§ 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
<b>DEPARTMENT OF VETERANS AFFAIRS CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS FOR GRANTEEES OTHER THAN INDIVIDUALS</b>
<p>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.</p>
<p>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).</p> <p><b>The grantee certifies that it will provide a drug-free workplace by:</b></p> <ol style="list-style-type: none"> <li>(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;</li> <li>(2) Establishing a drug-free awareness program to inform employees about             <ol style="list-style-type: none"> <li>(a) The dangers of drug abuse in the workplace;</li> <li>(b) The grantee's policy of maintaining a drug-free workplace;</li> <li>(c) Any available drug counseling, rehabilitation, and employee assistance programs; and</li> <li>(d) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;</li> </ol> </li> <li>(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);</li> <li>(4) Notifying the employee in the statement required by paragraph (1) that, as a condition of employment under the grant, the employee will             <ol style="list-style-type: none"> <li>(a) Abide by the terms of the statement; and</li> <li>(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;</li> </ol> </li> <li>(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;</li> <li>(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;             <ol style="list-style-type: none"> <li>(a) Taking appropriate personnel action against such employee, up to and including termination; or</li> <li>(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;</li> </ol> </li> <li>(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).</li> </ol>



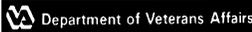
§ 58.16 VA Form 10-0144—Certification Regarding Lobbying.

OMB Number: 2900-0160  
Estimated Burden: 5 minutes

 Department of Veterans Affairs	
<b>CERTIFICATION REGARDING LOBBYING</b>	
<p>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.</p>	
<p>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).</p> <p>Certification for Contracts, Grants, Loans, and Cooperative Agreements</p> <p>The undersigned certified, to the best of their knowledge and belief, that:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>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.</p>	
SIGNATURE OF CERTIFYING OFFICIAL	DATE
NAME AND TITLE OF CERTIFYING OFFICIAL	PROJECT (FAI NUMBER)
NAME AND ADDRESS OF STATE AGENCY	

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

OMB Number: 2900-0160  
Estimated Burden: 5 minutes

	
<b>STATEMENT OF ASSURANCE OF COMPLIANCE WITH EQUAL OPPORTUNITY LAWS</b>	
<p>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.</p>	
_____(hereinafter called the "Signatory")	
(Name of Organization, Institution, or Individual)	
<p><b>HEREBY AGREES THAT:</b></p> <p>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.</p> <p>The Signatory HEREBY GIVES ASSURANCE that it will promptly take measures to effect this agreement.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
SIGNATURE OF AUTHORIZED OFFICIAL	DATE
NAME AND TITLE OF AUTHORIZED OFFICIAL	
MAILING ADDRESS OF AUTHORIZED OFFICIAL	

VA FORM 10-0144A  
APR 1999 (R)