§ 53.30 Payments.

(a) The amount of payments awarded under this part during a Federal fiscal year will be the amount requested by the State and approved by VA in accordance with this part. Payments may not exceed 50 percent of the cost of the employee incentive program for that fiscal year and may not exceed 2 percent of the amount of the total per diem payments estimated by VA to be made under 38 U.S.C. 1741 to the State for that SVH during that fiscal year for adult day health care, domiciliary care, hospital care, and nursing home care.

(b) Payments will be made by lump sum or installment as deemed appropriate by the Chief Consultant, Geriatrics and Extended Care.

(c) Payments will be made to the State or, if designated by the State representative, the SVH conducting the employee incentive program.

(d) Payments made under this part for a specific employee incentive program shall be used solely for that purpose.

§ 53.31 Annual report.

(a) A State receiving payment under this part shall provide to VA a report setting forth in detail the use of the funds, including a descriptive analysis of how effective the employee incentive program has been in improving nurse staffing in the SVH. The report shall be provided to VA within 60 days of the close of the Federal fiscal year (September 30) in which payment was made and shall be subject to audit by VA.

(b) A State receiving payment under this part shall also prepare audit reports as required by the Single Audit Act of 1984 (38 CFR part 41) and submit them to VA.

§ 53.32 Recapture provisions.

If a State fails to use the funds provided under this part for the purpose for which payment was made or receives more than is allowed under this part, the United States shall be entitled to recover from the State the amount not used for such purpose or the excess amount received.

§ 53.40 Submissions of information and documents.

All submissions of information and documents required to be presented to VA must be made to the Chief Consultant, Geriatrics and Extended Care (114), VHA Headquarters, 810 Vermont Avenue, NW., Washington, DC 20420.

§ 53.41 Notification of funding decision.

If the Chief Consultant, Geriatrics and Extended Care, determines that a submission from a State fails to meet the requirements of this part for funding, the Chief Consultant shall provide written notice of the decision and the reasons for the decision.

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 Forms 10-10EZ and 10-10EZR—Application for Health Benefits and Renewal Form.
58.13 VA Form 10-10SH—State Home Program Application for Veteran Care—Medical Certification.
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.
58.18 VA Form 10-0460—Request for Prescription Drugs from an Eligible Veteran in a State Home.


SOURCE: 65 FR 981, Jan. 6, 2000, unless otherwise noted.
§ 58.10 VA Form 10–3567—State Home Inspection Staffing Profile.

<table>
<thead>
<tr>
<th>PART I</th>
<th>TOTAL FACILITY</th>
<th>HOSPITAL</th>
<th>NHC</th>
<th>DOM</th>
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NAME OF HOME: 

DATE OF INSPECTION: 

1008
### PART III
#### HOSPITAL (Average hours Hosp. ________ )

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### PART IV
#### NURSING HOME (Average hours NHC ________ )

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### PART V
#### DOMICILIARY (Average hours Dom. ________ )

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

INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

1. USE OF VA FORM 10-5588, STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

The VA Form 10-5588 consists of several parts. This report is a monthly statement of gains and losses, days of care, average daily census, total per diem cost, per diem claimed and total amount claimed for hospital, nursing home, domiciliary, and adult day health care. The State home will be paid monthly. Payments will be made only after the State submits a completed VA Form 10-5588.

a. One copy of the monthly statement of account will be submitted by each State home to VA medical center of jurisdiction by the end of the 5th workday after the close of each monthly report period.

b. VA medical center of jurisdiction staff will review each monthly report for accuracy, resolve any discrepancies with the State home, make payment by electronic fund transfer and file the report. A report should not be accepted by a VA medical center staff if the report is incomplete (i.e., all appropriate blanks are complete and report is signed by the State home administrator and State employee when under management contract arrangement).

c. The original monthly statement will be verified and signed by the VA medical center staff person assigned as the point of contact for oversight of the State Home Program and forwarded in duplicate to the Business Office for audit and payment. On completion of VA accounting certification, one copy of each report will be sent to VA Central Office, not later than the 15th workday after the month ends. This information is used to prepare quarterly program reports of expenditures that are the basis or long range budget projections. The VA Central Office copy will be addressed to: Chief Consultant Chief State Home Per Diem Program, Office of Geriatrics and Extended Care (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420.

2. GENERAL INSTRUCTIONS

a. Enter the last day of the calendar month covered by the report in the box labeled "For Month Ending."

b. Enter line entries for domiciliary, column A; nursing home, column B; hospital, column C; or adult day health care, column D in appropriate columns.

c. Lines 1 through 13 are to be completed for each level of care. Lines 1-9 will be completed as a monthly veterans accountability. Lines 10-13 will be completed as the end of month resident accountability.

(1) Line 1, Total Veteran Residents Remaining End of Prior Month. Enter the number of veterans eligible residents present and remaining on the rolls of the State home as of midnight on the last day of the prior month. Entries on this line will be the same as those shown on line 9 for the prior month.

(2) Line 2, Admissions (Change of Status). Enter the number of eligible veterans whose status was changed by transfer from one level of care to another.

(3) Line 3, Admissions (Other). Enter the number of eligible veterans admitted to the State home during the report month.

(4) Line 4, Return From Leave of Absence of 10 consecutive overnight absences at a VA or other hospital for the first 12 other types of overnight absences in a calendar year.

(5) Line 5, Discharges (Change of Status). Enter the number of eligible veterans whose status was changed by transfer to another level of care in the State home. The total entries on line 2 and 5 for the month will be the same.

(6) Line 6, Discharges (Others). Enter the number of eligible veterans who were discharged from the State home or dropped from the rolls, except for deaths.

(7) Line 7, Deaths. Enter the number of eligible veterans who died during the report month. Attach a separate sheet to identify deaths by name.

(8) Line 8, Leave of Absence of 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year.

(9) Line 9, Total Veteran Residents Remaining End of Month. Enter the number of eligible male and female veterans present and remaining as of midnight on the last day of the report month. This entry will be equal to the sum of lines 1, 2, 3 and 4 minus lines 5, 6, 7 and 8.

(10) Line 10, Non-Veterans Residents Remaining End of Month. Enter number of residents not eligible for reimbursement by VA that are present on the last day of the report month. DO NOT REPORT eligible veteran residents in this cell.

(11) Line 11, Total Nursing Home Care Veterans that are 70% Disabled or Admitted for a Service Connected Condition. Enter number of residents included on line 9, that are over 70% service connected disabled or admitted for a service connected condition.

(12) Line 12, Female Veteran Residents Remaining at the end of the month.
CONTINUED INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID

(13) Line 13, Total Veteran Days of Care Provided. Enter total number of days of care provided, including days of care for eligible veterans absent 96 hours or less. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care. When accounting for Nursing Home Care use lines 13a and 13b.

(13a) Line 13a, Total Veteran Days of Care Provided for Nursing Home Care. Enter total number of days of care provided to veterans 70% or more disabled or admitted for a service connected disability, including days of care for eligible veterans with leaves of absence of 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care.

3. INSTRUCTIONS FOR MONTHLY SUMMARY STATEMENT ACCOUNT.

a. Column E, Days of Care, Lines 14, 15, 16, and 17. Enter from line 13 the data in columns A for domiciliary, C for hospital care and D for adult day health care to show the total number of days for each level of care for the month. Enter from line 13b for B for nursing home care to show the total number of day for Nursing home Care for patients less than 70% service disabled or not admitted for a service connected condition. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care.

b. Column F, Average Daily Census, Lines 14, 15, 16, and 17. Enter the average daily census computed by dividing the appropriate entry in column B by the number of calendar days in the month, carried to one decimal place.

c. Column G, Total Per Diem Cost, Lines 14, 15, 16, and 17. Enter on the appropriate line the total per diem costs for the month computed in accordance with relevant cost principles set forth in the Office of Management and Budget (OMB) Circular number A-87, dated May 4, 1995, "Cost Principles for State, Local, and Indian Tribal Governments." The total per diem cost will include the direct and indirect costs appropriate for each level of care.

d. Column H, Per Diem Claimed, 14, 15, 16, and 17. Enter the authorized (VA approved per diem rate for the Fiscal Year) per diem rate or one-half the amount shown in column G divided by two decimal places whichever is the lesser, for the appropriate level of care. VA will pay monthly one-half of the cost of each eligible veteran's care (domiciliary, nursing home, hospital or adult day health care) for each day the veteran is in a facility recognized as a State home, not to exceed the approved per diem rate for that level of care.

e. Column I, Total Amount Claimed.

(1) Line 18. Verify that the total amount claimed in line 17 does not exceed one-half the sum of products of entries in columns II and I, lines 14, 15, 16 and 17.

4. INSTRUCTIONS FOR CLAIM PER DIEM PAYMENTS OF 70% SC VETERANS IN STATE NURSING HOMES.

a. Column J, Days of Care, Lines 19 and 20 total number of days for each level of care for the month. Including days of care for eligible veterans absent 10 consecutive overnight absences at a VA or other hospital and for the first 12 other types of overnight absences in a calendar year. One day of care may be counted for a veteran on the day the veteran is admitted. A day of care is not counted on the day of discharge. A gain and a loss on the same day will be reported as one day of care. Total on line 21.

b. Column K, Total Veterans, Lines 19 and 20. Enter the total number of eligible veterans present on the last day of the report month on line 21.

c. Column L, Rate Per Day of SC Vet, 19 and 20. Use prevailing rate chart or (03) 15, whichever is less.

d. Column M, Amount Claimed, Lines 19 and 20. Enter the total amount by adding line 19 to line 20.

5. OPERATING BEDS

a. At the end of each month, State home management will enter the current operating bed capacities for domiciliary, nursing home, hospital or adult day health care in the appropriate spaces on Page 2 of the report form. Also on Page 2, facility management will enter bed capacities approved by VA. The approved bed capacity and the operating beds should be the same number of beds. If operating beds are closed for any reason, facility management is required to provide the date of closure, expected date the beds will be operational, type of bed (domiciliary, nursing home, hospital, or adult day health care), and the reason for the closure. Please specify if these beds were constructed with federal funds. Information related to closed beds may be entered under "Remarks".

6. CERTIFICATION

a. The facility management must certify that the information in the report is correct by signing and dating the report.

b. If the facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time, on-site basis. This State employee must also certify that the information in the report is correct by signing and dating the report.
## STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

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<th>Line No</th>
<th>Item</th>
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<th>Hospital (C)</th>
<th>Adult Day Health Care (D)</th>
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<td>DISCHARGES (Change of status)</td>
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### STATUS AS OF THE END OF THE MONTH

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### TOTAL DAYS OF CARE FOR THE MONTH

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<th>Hospital (C)</th>
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<tr>
<td>13</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

<table>
<thead>
<tr>
<th>LINE NO.</th>
<th>FEDERAL AID CLAIMED UNDER SEC. 1741, TITLE 38, U.S.C., AS AMENDED</th>
<th>DAYS OF CARE (E)</th>
<th>AVERAGE DAILY CENSUS (F)</th>
<th>DAILY COST OF CARE FOR THE MONTH* (G)</th>
<th>PER DIEM CLAIMED (H)</th>
<th>TOTAL AMOUNT CLAIMED (I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>DOMICILIARY CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>NURSING HOME</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>HOSPITAL CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>ADULT DAY HEALTH CARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>TOTAL AMOUNT CLAIMED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CLAIM FOR PER DIEM PAYMENTS FOR CERTAIN SC VETERANS IN STATE NURSING HOMES

<table>
<thead>
<tr>
<th>LINE NO.</th>
<th>VETERAN CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>HAS A SINGULAR OR COMBINED RATING OF 70% OR MORE BASED ON 1 OR MORE SERVICE-CONNECTED DISABILITIES OR A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY</td>
</tr>
<tr>
<td>20</td>
<td>IS IN NEED OF INH CARE FOR A VA AGRICULTURAL RD DISABILITY</td>
</tr>
<tr>
<td>21</td>
<td>TOTALS:</td>
</tr>
</tbody>
</table>

FOR UNITED STATES DEPARTMENT OF VETERANS AFFAIRS USE ONLY

I certify that this report is correct based on documentation provided to VA and that the bed capacity approved by VA is correct.

### BED CAPACITY APPROVED BY VA

<table>
<thead>
<tr>
<th>DOMICILIARY CARE</th>
<th>NURSING HOME CARE</th>
<th>HOSPITAL CARE</th>
<th>ADULT DAY HEALTH CARE</th>
</tr>
</thead>
</table>

### RECEIVING REPORT

- Services authorized under provisions of Sec. 1741, 1742, 1743 and 1745, Title 38, U.S.C., have been rendered in the quantity claimed and payment is recommended except as follows:

| TOTAL AMOUNT APPROVED BY VA FOR PAYMENT (add block 19I and 21M) |
|=================================================================|
| SIGNATURE AND TITLE OF VA STATE HOME COORDINATOR                 |
| DATE                                                             |

<table>
<thead>
<tr>
<th>ACCOUNTING CERTIFICATION - AUDIT BLOCK</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMOUNT DUE</td>
</tr>
<tr>
<td>SIGNATURE AND TITLE OF AUDITOR</td>
</tr>
</tbody>
</table>

The daily cost of care per veteran is the direct cost plus the indirect cost for the month, divided by patients or residents days of care. Compute this cost in accordance with relevant cost principles set forth in the Office of Management and Budget (OMB) Circular number A-87, dated May 4, 1995, Cost Principles for State, Local, and Indian Tribal Governments.
STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

<table>
<thead>
<tr>
<th>TOTAL STATE OPERATING BEDS AT END OF THE MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOMICILIARY CARE</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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 1964.

SIGNATURE OF STATE HOME ADMINISTRATOR
SIGNATURE OF STATE EMPLOYEE WHEN APPROPRIABLE

DATE
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. Although completion of this form is voluntary, VA will be unable to provide reimbursement for services rendered without a completed form. Failure to complete the form will have no effect on any other benefits to which you may be entitled. This information is collected under the authority of Title 38 CFR Parts 51 and 52.

VA Form 10-6586
Jul 2008

(65 FR 981, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009)
§ 58.12 VA Forms 10–10EZ and 10–10EZR—Application for Health Benefits and Renewal Form.

![Application for Health Benefits Form]

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)
### APPLICATION FOR HEALTH BENEFITS, Continued

#### SECTION II - INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you covered by health insurance (including any employment-related group or similar plan)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of policy holder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you eligible for medicare?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you enrolled in Medicare-issued hospital insurance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you enrolled in Medicare-issued hospital insurance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name exactly as it appears on your Medicare card</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### SECTION III - EMPLOYMENT INFORMATION

<table>
<thead>
<tr>
<th>Employment Status (Check one)</th>
<th>Full Time</th>
<th>Part Time</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of retirement (month/year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company name, address and telephone number</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### SECTION IV - MILITARY SERVICE INFORMATION

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Last Discharge Date</th>
<th>Last Discharge Oath</th>
<th>Type of Discharge</th>
<th>Period of Duty</th>
</tr>
</thead>
</table>

#### Privacy Act Information

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

**VA Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA 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.

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10-10EZ

PAGE 2

1017
### Application for Health Benefits, Continued

#### Section VI: Financial Disclosure

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling any applicants who decline to provide their financial information unless they have a special eligibility factor. Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information but the other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience.

- **Yes**, I will provide my household financial information for last calendar year. Complete applicable sections VII through X. **Sign and date the form in Section XII.**

#### Section VII: Dependent Information (Use a separate sheet for additional dependents)

<table>
<thead>
<tr>
<th>Dependents' Name</th>
<th>S/A/C/D (Last, First, Middle, Initial)</th>
<th>S/A/C/D (Last, First, Middle, Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Holography</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section VIII: Previous Annual Income of Veteran, Spouse, and Dependent Children

<table>
<thead>
<tr>
<th>Description</th>
<th>Veteran</th>
<th>Spouse</th>
<th>Child 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Annual Income from Employment (wages, salaries, tips, etc.)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Excluding Income from Your Farm, Ranch, Property or Business</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>1. Net Income from Your Farm, Ranch, Property or Business</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2. Last Other Income Amounts (e.g., Social Security, compensation, pension, retirement, dividends)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

#### Section IX: Previous Calendar Year Deductible Expenses

- **Total nonzero deductions for medical expenses incurred in the previous calendar year**

#### Section X: Previous Calendar Year Net Worth

- **Total value of all assets and property of a veteran or dependents (use schedule information in Section XI)**

#### Section XI: Consent to Enrollment

If you are a 10% service-connected veteran and do not receive VA monetary benefits or a non-Veteran (and you are not a Former POW, Purple Heart Recipient or VA permanent) and your household income (if combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but we will not pay any VA benefits for services related to your non-service-connected conditions. If you are a veterans by signing this application, you are agreeing to pay the applicable VA expenses.

---

**VA Form 10-10EZ**

**PAGE 3**
Department of Veterans Affairs

§ 58.12

Health Benefits Renewal Form

Section I - General Information

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for making a materially false statement (see 18 U.S.C. 1001).

1. Veteran's Name (Last, First, Middle Initial)
2. Other Names Used
3. Gender
   Male  Female
4. Social Security Number
5. Date of Birth (mm/dd/yyyy)
6. Permanent Address (Street)
7. City
8. State
9. Zip
10. County
11. Home Telephone Number (Include area code)
12. Email Address
13. Current Marital Status (Choose one)
   Married  Never Married  Separated  Widowed  Divorced  Unknown
14. Name and Address and Relationship of Next of Kin
   Next of Kin's Home Telephone Number (Include area code)
15. Next of Kin's Work Telephone Number (Include area code)
16. Emergency Contact
   Emergency Contact's Home Telephone Number (Include area code)
17. Emergency Contact's Work Telephone Number (Include area code)

Section II - Insurance Information (Use a separate sheet for additional information)

18. Are You Covered by Health Insurance, Including Coverage Through a Spouse or Other Person?  Yes  No
19. Name of Policy Holder
20. Policy Number
21. Group Code
22. Are You Eligible for Medicare?  Yes  No
23. Effective Date (mm/dd/yyyy)
24. Are You Enrolled in Medicare Hospital Insurance?  Yes  No
25. Effective Date (mm/dd/yyyy)
26. Are You Enrolled in Medicare Part A?  Yes  No
27. Medicare Claim Number

Section III - Employment Information

28. Veteran's Employment Status (Choose one)
   Full Time  Part Time  Retired
   If Employed or Retired,Complete line 1a.
   Date of retirement
29. Company Name, Address and Telephone Number

Section IV - Paperwork Reduction Act and Privacy Act Information

VA is asking you to provide the information on this form under 5 U.S.C. Sections 1775, 1772, and 17761 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer matching program. VA may disclose the information you put on the form to persons authorized to review your records in the course of their official duties. VA may refuse to provide VA benefits and benefits under VA administered non-Veterans Affairs programs to any person you may refuse to provide VA benefits and benefits under VA administered non-Veterans Affairs programs to any person for whom it deems it necessary to protect the health and well-being of other persons.

VA Form

10-10EZ-R

July 2006

Previous editions of this form are not to be used.
§ 58.12  38 CFR Ch. I (7–1–11 Edition)

Department of Veterans Affairs

VETERANS NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

SECTION V - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Recent combat veterans (e.g., OEF/OIF) file other veterans may answer YES in Section V and complete Sections VI and IX to have their priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of service-connected conditions assessed.

No, I do not wish to provide financial information in Sections VI through IX. If I am misled, I agree to pay applicable VA copayments. Sign and date the form in Section IX.

Yes, I will provide my household financial information for last calendar year. Complete applicable Sections VI through IX. Sign and date the form in Section IX.

SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. SPOUSE'S NAME (Last, First, Middle Name)

2. CHILD'S NAME (Last, First, Middle Name)

3. SPOUSE'S SOCIAL SECURITY NUMBER

4. CHILD'S SOCIAL SECURITY NUMBER

5. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)

6. CHILD'S DATE OF BIRTH (mm/dd/yyyy)

7. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (Street, City, State, ZIP)

8. CHILD'S ADDRESS AND TELEPHONE NUMBER (Street, City, State, ZIP)

9. IF YOUR SPOUSE (OR DEPENDENT) CHANGED HIS OR HER NAME YOU LAST YEAR, ENTER THE MANNER YOU CONTRIBUTED TO THEIR SUPPORT

10. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL, REHABILITATION OR TRAINING (e.g., tuition, books, materials)

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)

1. GROSS ANNUAL INCOME FROM OWN CONDUCT (e.g., wages, dividends, tips, etc.)

2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS

3. LIST OTHER INCOME (e.g., Social Security, compensation, pensions, interest, dividends, excluded VISTA)

SECTION VIII - PREVIOUS CALENDAR YEAR DEPENDABLE EXPENSES

1. TOT. NON-NEGOCIABLE MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE LAST CALENDAR YEAR (e.g., prescriptions, dental care, medications, medical equipment, health insurance, hospice and nursing home) VA will calculate this based on the medical expenses you list and your income.

2. ITEMIZED AND TOTAL DEDUCTIBLE EXPENSES FOR YOUR DISABILITY SPOUSE OR DEPENDENT CHILD (If listed on itemized information in Section IX)

3. AMOUNT YOU INVESTED CALENDAR YEAR FOR YOUR COLLEGE, VOCATIONAL, EDUCATIONAL EXPENSES (e.g., tuition, books, fees, living costs) NOT EVEN TOTAL OF LIFETIME EXPENSES (Use a separate sheet for additional dependents)

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)

1. CASH, MARKET VALUE ACCOUNTS (e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)

2. MARKET VALUE OF LAND AND BUILDINGS LESS MORTGAGE INVESTMENTS (e.g., second homes and farm, and income-producing property) DO NOT INCLUDE YOUR PRIMARY HOME.

3. MARKET VALUE OF OTHER PROPERTY OR ASSETS (e.g., car, mobile home, valuables, assets, etc.) MARKET VALUE OF LAND, BUILDING, BUSINESS, ESTATE, ESTATE OF DEEDS, TITLE, RENTAL AGREEMENTS, AND REAL PROPERTY

SECTION X - CONSENT TO COPAYMENTS

I authorize VA to contact my private current and former VA providers (e.g., United States Government Affiliated Policies) and/or private caregivers and/or insurance for a complete and accurate VA copayments for the services provided. This information will be used to determine your priority for enrollment, but only if there is a VA copay system in place as required by law.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS ON WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURES OF APPLICANTS

PAGE 2

1020

(65 FR 981, Jan. 6, 2000, as amended at 74 FR 19439, Apr. 29, 2009)
§ 58.13 VA Form 10–10SH—State Home Program Application for Veteran Care Medical Certification.

<table>
<thead>
<tr>
<th>STATE HOME FACILITY</th>
<th>DATE ADMITTED</th>
<th>GENDER M F</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENT’S NAME (Last, First, Middle) (This is a mandatory field)</td>
<td>SOCIAL SECURITY NUMBER (If necessary)</td>
<td></td>
</tr>
<tr>
<td>RESIDENT’S STREET ADDRESS</td>
<td>AGE</td>
<td>DATE OF BIRTH (mm/dd/yyyy)</td>
</tr>
<tr>
<td>CITY, STATE AND ZIP CODE</td>
<td>ADVANCED MEDICAL DIRECTIVE NO YES</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HISTORY</th>
<th></th>
</tr>
</thead>
</table>

**HEIGHT** | **WEIGHT** | **TEMP** | **PULSE** | **BP** | **HEAD/VESTIGIALS AND THROAT**

**NECK** | **CARDIOPULMONARY** |

**ABDOMEN** | **GENITOURINARY** |

**RECTAL** | **EXTREMITIES** |

**NEUROLOGICAL** | **ALLERGIES/SENSITIVITY** |

**CHEST X-RAY**

<table>
<thead>
<tr>
<th>DATE (mm/dd/yyyy)</th>
<th>RESULTS</th>
<th>CBC</th>
<th>DATE (mm/dd/yyyy)</th>
<th>RESULTS</th>
</tr>
</thead>
</table>

**SEROLOGY**

<table>
<thead>
<tr>
<th>DATE (mm/dd/yyyy)</th>
<th>ALBUMEN</th>
<th>SUGAR</th>
<th>ACETONE</th>
</tr>
</thead>
</table>

**URINALYSIS**

<table>
<thead>
<tr>
<th>DATE (mm/dd/yyyy)</th>
<th>ALBUMEN</th>
<th>SUGAR</th>
<th>ACETONE</th>
</tr>
</thead>
</table>

**CHECK ALL BOXES THAT APPLY OR CHECK NA**

- IS DEMENTIA THE PRIMARY DIAGNOSIS
- IS THERE A DIAGNOSIS OF MENTAL ILLNESS
- HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 5 YEARS
- IS CLIENT A DANGER TO SELF OR OTHERS

**IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS**

- SCHIZOPHRENIA
- PARANOID
- MOOD SWINGS
- SOMATOFORM DISORDER
- PANIC OR SEVERE ANXIETY DISORDER

**OXYGEN**

- NASAL CANAL
- CONTINUOUS

**TYPE OF CARE RECOMMENDED**

- SKILLED NURSING HOME CARE
- DOMICILIARY CARE
- ADULT HEALTH CARE
- HOSPITAL

**REFERRING PHYSICIAN**

- PRIMARY DIAGNOSIS
- TERTIARY DIAGNOSIS

**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**

**Social Security Number**

**EVALUATION** (Select an appropriate number in each category)

### Communication
- 1. Transmits messages/receives information
- 2. Limited speech
- 3. Wrinkled and slurred
- 4. Unable to speak clearly or at all

### Hearing
- 1. Normal
- 2. Hearing slightly impaired
- 3. Hard of hearing
- 4. Completely deaf

### Transfer
- 1. No assistance
- 2. Equipment only
- 3. Supervision only
- 4. Requires human transfer plus equipment
- 5. Bedlift

### Endurance
- 1. Can't walk or stand (25 feet or more)
- 2. Needs assistance and often
- 3. Wrinkles sheet and activities
- 4. No assistance

### Toileting
- 1. No assistance
- 2. Assistance and form
- 3. Total assistance including personal hygiene
- 4. Help with clothes

### Dressing
- 1. Needs help to complete dressing
- 2. Minor assistance
- 3. No assistance or need to be dressed
- 4. To be dressed

### Bladder Control
- 1. Continuous
- 2. Mostly incontinent
- 3. Occasional - no leakage or loss
- 4. Frequent - up to once a day
- 5. Total incontinence
- 6. Catheter/indwelling

### Skin Condition
- 1. Wound
- 2. Pressure sores
- 3. Infections (Fistula)
- 4. Open wound
- 5. Decubitus

### Wheelchair Use
- 1. Independent
- 2. Assistance in difficult maneuvering
- 3. Needs a few feet
- 4. Unable to use

**Signature of Registered Nurse or Referring Physician**

**Date**

**Physical Therapy** (To be completed by Physical Therapist or Referring Physician)

- **Need Referral**
- **Continuation of Therapy**

**Sensory Impairments**

- **Restrict Activity**
- **Frequencies of Treatment**

**Treatment Goals**

- **Stretching**
- **Progressive Resistant**

**Additional Therapies**

- **Speech**
- **Dietary**

**Social Work Assessment** (To be completed by Social Worker)

**Long Range Plan**

**Authorization for Payment**

**Date Received by VA**

**Eligibility of Payment**

**Signed of VA Official**

**Date**

**Signature of VA Physician**

**Date**

---

1022
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. 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.

(65 FR 981, Jan. 6, 2000, as amended at 74 FR 19444, Apr. 29, 2009)

<table>
<thead>
<tr>
<th>STATEMENT OF ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| (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 statutes 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.

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<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED OFFICIAL</th>
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<td>TITLE</td>
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| MAILING ADDRESS |
§ 58.15 VA Form 10–0143—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).
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)

<table>
<thead>
<tr>
<th>ORGANIZATION NAME</th>
<th>GRANT NUMBER OR NAME</th>
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</thead>
<tbody>
<tr>
<td>NAME AND TITLE OF AUTHORIZED REPRESENTATIVE</td>
<td></td>
</tr>
<tr>
<td>SIGNATURE</td>
<td>DATE</td>
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</tbody>
</table>

10-0143 REPRODUCE LOCALLY
§ 58.16 VA Form 10–0144—Certification Regarding Lobbying.

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 Form-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.

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<th>SIGNATURE OF CERTIFYING OFFICIAL</th>
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<tr>
<td>NAME AND TITLE OF CERTIFYING OFFICIAL</td>
<td>PROJECT (FAA NUMBER)</td>
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<tr>
<td>NAME AND ADDRESS OF STATE AGENCY</td>
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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.

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

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 Veterans 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 (l) of Title 38, U.S.C. Also, sections 1713, 1720, 1720A, 1741-1743, 2408, 5920(a)(2), 8131-8137, 8151-8156 (formerly 613, 620, 620A, 641-643, 1008, 3402(a)(2), 5301-5307, 5301-5306 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
§ 58.18 VA Form 10–0460—Request for Prescription Drugs from an Eligible Veteran in a State Home.

I am a veteran who was admitted to the State Nursing Home. I request that I be furnished with prescription drugs by the United States Department of Veterans Affairs as provided for in Title 38 of the Code of Federal Regulations, Sections 17.96 and/or 51.42.

I am eligible for this benefit by reason of being (check any of the following):

□ (1) a veteran in receipt of increased VA compensation, or increased VA pension because I am permanently housebound or in need of regular aid and attendance.

□ (2) a veteran in need of regular aid and attendance who was formerly in receipt of increased pension but whose pension has been discontinued solely by reason of excess income, and whose annual income does not exceed the maximum annual income limitation by more than $1,000.

□ (3) a veteran who
   (i) has a single or combined rating of 50 percent or 60 percent based on one or more service-connected disabilities or unemployability and is in need of such drugs and medicines; and
   (ii) is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

□ (4) a veteran who
   (i) has a single or combined rating of less than 50 percent, based on one or more service-connected disabilities, and is in need of such drugs and medicines for a service-connected disability, and
   (ii) is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

__________________________________________
Signature of Veteran Applying for Benefit

__________________________________________
Date of Application

Applicant Information

Veteran’s Name (last, first, and middle initial):

Veteran’s Social Security Number: 

Date of Admission to the State Nursing Home:

Date that A&A or Housebound was awarded by VA:
   (a copy of this award □ is or □ is not attached with this request)
## Diagnosis/Diagnoses for which the Applicant was Admitted to the State Nursing Home

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
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<th>Category of Eligibility from page 1</th>
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Name of Prescribing Physician: __________________________ Telephone Number: __________________________

I certify that the following medications are prescribed for __________________________

Veteran's Name: __________________________

Signature of State Home Representative: __________________________
PART 59—GRANTS TO STATES FOR CONSTRUCTION OR ACQUISITION OF STATE HOMES

Sec. 59.1 Purpose.

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 this Act. We may not conduct or sponsor, and the respondent is not required to respond to, a collection unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, gathering the necessary facts and filling out the form. This information is collected under the authority of Title 38 CFR Parts 51 and 58. It is being collected under the medical benefits in the State Homes Program and will be used for that purpose.

Privacy Act Information: It is being collected to enable us to determine your eligibility for medical benefits 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 mandatory. 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.