OMB Control No: 2900-0160
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Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED *(MM/DD/YYYY)*

3. STATE HOME FACILITY ADDRESS *(Street, City, State and Zip Code)*

4. RESIDENT'S NAME *(Last, First, Middle)*

5. SOCIAL SECURITY NUMBER	6. SEX	7. AGE	8. DATE OF BIRTH *(MM/DD/YYYY)*	9. ADVANCED MEDICAL DIRECTIVE
	☐ M ☐ F			☐ NO ☐ YES

10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?

☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

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

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK	19. CARDIOPULMONARY
20. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB								
	CHEST X-RAY	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A	CBC	DATE *(MM/DD/YYYY)*	RESULT	☐ N/A
	SEROLOGY							☐ N/A
	URINALYSIS	DATE *(MM/DD/YYYY)*	ALBUMIN		ACETONE		SUGAR	☐ N/A

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS	30. IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER ☐ N/A

32. OXYGEN	33. FEEDING	34. WOUND	35. FOLEY CATHETER
☐ MASK ☐ PRN ☐ CONTINUOUS ☐ NASAL CANNULA ☐ N/A	☐ TUBE FEEDING ☐ OSTOMY ☐ TRACHEOSTOMY ☐ N/A	☐ DECUBITUS ULCERS ☐ DRAINING WOUND ☐ WOUND CULTURED ☐ N/A	☐ TEMPORARY ☐ PERMANENT ☐ N/A

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN

41. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

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

43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA	44. SIGNATURE OF SVH PHYSICIAN/APRN/PA **NOTE:** This field cannot be signed without first filling out item numbers 36 through 43. After signing, all fields in Part 2 will become locked and read only.

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PART III - EVALUATION *(Select an appropriate number in each category)*

45. RESIDENT'S NAME *(Last, First, Middle)*	46. SOCIAL SECURITY NUMBER

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

47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA	48. DATE *(MM/DD/YYYY)*
NOTE: After signing, all fields in Part 3 will become locked and read only.	

PHYSICAL THERAPY ***(To be completed by Physical Therapist or Physician/APRN/PA)*** 49. Check if ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY ☐ N/A

50. SENSATION IMPAIRED	51. RESTRICT ACTIVITY	52. PRECAUTIONS	53. FREQUENCY OF TREATMENT
☐ YES ☐ NO	☐ YES ☐ NO	☐ CARDIAC ☐ OTHER *(Type other, specify)*	

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

55. ADDITIONAL THERAPIES	56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA	57. DATE *(MM/DD/YYYY)*
☐ O.T. ☐ SPEECH ☐ DIETARY	**NOTE:** After signing, all fields under Physical Therapy will become locked and read only.	

PART IV - SOCIAL WORK ASSESSMENT *(To be completed by SVH Social Worker (SW) or Physician/APRN/PA)*

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN

60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS	61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA

62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA	63. DATE *(MM/DD/YYYY)*
NOTE: After signing, all fields in Part 4 will become locked and read only.	

64. REMARKS *(Attach additional sheets if necessary)*

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART V - VA AUTHORIZATION FOR PAYMENT

65. RESIDENT'S NAME *(Last, First, Middle)*

66. SOCIAL SECURITY NUMBER

ADMINISTRATIVE REVIEW

67. 10-10EZ OR 10-10EZR HAS BEEN RECEIVED WITH 10-10SH:
☐ YES ☐ NO ☐ N/A (ELECTRONIC VERSION COMPLETED)

68. DATE ADMITTED TO SVH *(MM/DD/YYYY)*:

69. DATE RECEIVED BY VA *(MM/DD/YYYY)*:

70. VETERAN ELIGIBLE FOR PER DIEM PAYMENT:
☐ BASIC ☐ PREVAILING ☐ NO

71. REMARKS *(Attach additional sheets if necessary)*:

NOTE: After signing, all fields in Part 5, Administrative Review will become locked and read only.

72. SIGNATURE OF VA ADMINISTRATIVE REVIEWER

73. DATE *(MM/DD/YYYY)*

CLINICAL REVIEW

74. IS VETERAN BEING ADMITTED DUE TO SC CONDITION?
☐ YES ☐ NO

75. SERVICE CONNECTED CONDITION BEING ADMITTED FOR:

NURSING HOME CARE

76. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE:
☐ YES ☐ NO

DOMICILIARY CARE *(See Instructions for Clarification)*

77. DOES VETERAN HAVE "NO ADEQUATE MEANS OF SUPPORT"?
☐ YES ☐ NO

78. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE:
☐ YES ☐ NO

ADULT DAY HEALTH CARE *(See Instructions for Clarification)*

79. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE?
☐ YES ☐ NO

80. VETERAN APPROVED FOR ADULT DAY HEALTH CARE:
☐ YES ☐ NO

81. REMARKS:

NOTE: After signing, all fields in Part 5, Clinical Review, Nursing Home Care, Domiciliary Care, and Adult Day Health Care will become locked and read only.

82. SIGNATURE OF VA PHYSICIAN/APRN/PA

83. DATE *(MM/DD/YYYY)*

PAPERWORK REDUCTION ACT OF 1995 AND PRIVACY ACT STATEMENT

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 who must complete this form will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: The information requested on this form is solicited under the authority of Title 38, U.S.C. Sections 1741, 1743 and 1745. It is being collected to enable us to determine eligibility for health benefits in the State Home Program and will be used for that purpose. The information 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all 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 the Veteran may be entitled. The disclosure of Social Security Number; VA will use it to administer 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.

Department of Veterans Affairs

VA FORM 10-10SH - INSTRUCTIONS

As a condition for VA approved State Veterans Home (SVH) to receive payment of per diem, the State Home must submit to the VA Medical Center of jurisdiction for each Veteran a completed VA Form 10-10SH, State Home Program Application for Care Medical Certification and a 10-10EZ, Application for Health Benefits or 10-10EZR, Health Benefits Update Form. Use additional sheets if needed containing the Veteran's name and Social Security Number. **If** you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

PART I - ADMINISTRATIVE

This section must be completed in full by State Veterans Home designated staff.

1. STATE HOME FACILITY - Enter the name of the facility
2. DATE ADMITTED - Select the date admitted using the calendar or enter the date as MM/DD/YYYY
3. STATE HOME FACILITY ADDRESS - Enter complete address
4. RESIDENT'S NAME - Enter the full name of the person to whom this application applies
5. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant
6. SEX - Check the appropriate box
7. AGE - Age of applicant
8. DATE OF BIRTH - Enter the date of birth in the format MM/DD/YYYY
9. ADVANCED MEDICAL DIRECTIVE - Check No or Yes
10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS? Check Yes, No, or N/A.
    10-10EZ or 10-10EZR is required to be submitted either in paper form or electronically with the 10-10SH. Note: N/A is used for admission application for NHC and ADHC.

PART II - HISTORY AND PHYSICAL

This section must be completed in full by State Veterans Home designated staff. The completed VA Form 10-10SH must contain sufficient medical information to justify the level of care that is to be provided to the Veteran. Failure to submit or complete this form correctly may result in denial or delay of VA per diem payment.

11. HISTORY - Enter the patient background and history
12. HEIGHT - Enter the applicant's height
13. WEIGHT - Enter the applicant's weight
14. TEMP - Enter the applicant's temperature
15. PULSE - Enter the applicant's pulse rate
16. BP - Enter the applicant's blood pressure
17. HEAD/EYES/EARS/NOSE AND THROAT - Enter any problems with the head, eyes, ears, nose and throat or N/A
18. NECK - Enter any problems with the neck or N/A
19. CARDIOPULMONARY - Enter any problems with the heart or N/A
20. ABDOMEN - Enter any problems with the abdomen or N/A
21. GENITOURINARY - Enter any problems with the genitourinary system or N/A
22. RECTAL - Enter any problems with the rectum or N/A
23. EXTREMITIES - Enter any problems with the extremities or N/A
24. NEUROLOGICAL - Enter any problems neurologically or N/A
25. ALLERGY/DRUG SENSITIVITY - Enter any allergies or sensitivities or N/A
26. X-RAY/LAB - Date of chest x-ray, results; CBC date, result; serology; urinalysis date, albumin, sugar, acetone or N/A
27. IS DEMENTIA THE PRIMARY DIAGNOSIS? Check Yes, No or N/A (not applicable)
28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS? Check Yes, No or N/A (not applicable)
29. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS? Check Yes, No or N/A (not applicable)
30. IS CLIENT A DANGER TO SELF OR OTHERS? Check Yes, No or N/A (not applicable)
31. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS - Check all that apply or check N/A
32. OXYGEN - Check all that apply or check N/A
33. FEEDING - Check all that apply or check N/A
34. WOUND - Check all that apply or check N/A
35. FOLEY CATHETER - Check all that apply or check N/A
36. REFERRING PHYSICIAN - Enter the name of the referring physician
37. PRIMARY DIAGNOSIS - Enter the primary diagnosis
38. SECONDARY DIAGNOSIS - Enter the secondary diagnosis
39. TERTIARY DIAGNOSIS - Enter the tertiary diagnosis
40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? Check Yes, No or Unknown
41. TYPE OF CARE RECOMMENDED - Choose the appropriate care
42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY - Enter all medications and treatment orders on the applicant.
43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA - Print or Type name of SVH Physician, or Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)
44. SIGNATURE OF SVH PHYSICIAN/APRN/PA - Enter signature

PART III - EVALUATION *(To be completed by SVH)*

45. RESIDENT'S NAME - Enter the full name of the person in which this application applies
46. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant
47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA - Enter signature
48. DATE - Enter date signed by registered nurse or Physician/APRN/PA

PHYSICAL THERAPY

49. Check the box if new or continued therapy or N/A
50. SENSATION IMPAIRED? Check Yes or No
51. RESTRICT ACTIVITY? Check Yes or No
52. PRECAUTIONS - Check if there is a cardiac or other (for other type over the text in the box)
53. FREQUENCY OF TREATMENT - Enter how often the applicant receives physical therapy
54. TREATMENT GOALS - Check all that apply
55. ADDITIONAL THERAPIES - Check all that apply
56. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA - Enter signature
57. DATE - Enter the date the Therapist or Physician signed (format MM/DD/YYYY)

PART IV - SOCIAL WORK ASSESSMENT ***(To be completed by SVH Social Worker (SW) or Physician/APRN/PA)***

58. PRIOR LIVING ARRANGEMENTS
59. LONG RANGE PLAN
60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS - Explain Veteran's ability to adjust to their illness/disability, living environment and make competent decisions
61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA - Print or type name of Social Worker (SW) or Physician/APRN/PA
62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA - Enter signature
63. DATE
64. REMARKS - For domiciliary care, the State Home must provide justification to support this level of care (see numbers 77 and 78).

PART V - VA AUTHORIZATION FOR PAYMENT

Completed in full by VA Medical Center of Jurisdiction designated staff

65. RESIDENT'S NAME - Enter the full name of the person in which this application applies
66. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant

ADMINISTRATIVE REVIEW SECTION

67. 10-10EZ OR 10-10EZR RECIEVED WITH 10-10SH - Check the appropriate if the forms were received with the 10-10SH or if the forms were completed electronically.
68. DATE ADMITTED TO SVH - Enter the date the Veteran was physically admitted to the State Veteran's Home
69. DATE RECEIVED BY VA - Enter the date the complete admission application was received by the VA.
70. VETERAN ELIGIBLE FOR PER DIEM PAYMENT - Check either Basic or Prevailing for eligible Veteran; or No if not eligible. Veteran is eligible if they are not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service. For Domiciliary Care, Veteran's income from the 10-10EZ must meet the Aid and Attendance threshold or determination for Domiciliary Care is made by Clinical Reviewer. For ADHC, Veteran must be enrolled in the VA health care system at the time of the application.
71. REMARKS - Enter any remarks regarding Administrative Review section. If Veteran is not eligible, enter reason per diem is denied.
72. SIGNATURE OF VA ADMINISTRATIVE REVIEWER - Enter signature.
73. DATE - Date of Administrative Reviewer's signature.

CLINICAL REVIEW SECTION

74. IS VETERAN BEING ADMITTED DUE TO SC CONDITION? Check YES or NO.
75. SERVICE CONNECTED CONDITION BEING ADMITTED FOR - If necessary, review VA databases such as VISTA, HINQ, VIS, VBMS, or CPRS for Veteran's service-connection condition/rating. If the reason the Veteran is being admitted for nursing home or adult day health care for a SC condition, enter the service-connected condition the Veteran is being admitted for.

NURSING HOME CARE

76. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE - Check YES or NO.

DOMICILIARY CARE

77. DOES VETERAN HAVE "NO ADEQUATE MEANS OF SUPPORT" - When an applicant's annual income exceeds the rate of pension, VA will determine if the applicant has no adequate means of support. This determination will be made based on an assessment of the Veteran's deficits in health or functional status that may render the Veteran incapable of achieving or sustaining independence in the community as determined by the Chief of Staff of the VA medical center of jurisdiction, or designee. Assessment will be based on objective evidence that considers factors that are inclusive of but not limited to:

    (1) Impact of the severity of the Veteran's medical condition, disabilities, and symptoms on the Veteran's safety in the community or ability to provide self-care or ability to access and utilize community support systems;

    (2) The availability of community or family support systems;

    (3) The risk of loss of housing in the community or Veteran's income;

    (4) Access to outpatient mental health and substance use disorder care; and the current effectiveness of any outpatient mental health and substance use disorder care; and

    (5) The current effectiveness of any outpatient mental health and substance abuse disorder care provided to the Veteran.

    Check "**Yes**" for Veteran who has deficits in health or functional status rendering the Veteran incapable of achieving or sustaining independence in the community.
    Check "**No**" for Veteran who has no deficits in health or functional status rendering the Veteran capable of achieving or sustaining independence in the community or in need of skilled nursing home care. Per diem is not approved.

78. Is Veteran capable of performing the following Activities of Daily Living (ADLs)?

    (1) Daily ablutions, such as brushing teeth, bathing, combing hair, and body eliminations, without assistance

    (2) Dress himself or herself with a minimum of assistance.

    (3) Proceed to and return from the dining hall without aid.

    (4) Feed himself or herself.

    (5) Secure medical attention on an ambulatory basis or by use of a personally propelled wheelchair.

    (6) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.

    (7) Make rational and competent decisions as to the Veteran's desire to remain in or leave the State home; or, if the Veteran lacks the general capacity to make this residential care placement decision, as defined by State law, then the Veteran's legal representative designated in accordance with State law, is authorized to make this decision on behalf of the Veteran.

    The Chief of Staff of the VA medical center of jurisdiction, or designee (e.g. VA Clinician) will review the 10-10SH form and determine whether the Veteran is able to perform the seven ADLs based on the information provided. If the Veteran can perform not fewer than four ADLs, the VA Clinician may waive the requirements and approve domiciliary level of care if it is in the best interest of the Veteran. In granting a waiver, the VA Clinician must make a finding that the State home has the capability to provide the domiciliary care that the Veteran needs.
    If the conditions are met, check "**Yes**" in the appropriate box and if Domiciliary Care is in the best interest of the Veteran and a waiver is approved, provide justification in remarks.
    If these conditions are not met, check "**No**" in the appropriate box and per diem is not approved.

PART V - VA AUTHORIZATION FOR PAYMENT

Completed in full by VA Medical Center of Jurisdiction designated staff

ADULT DAY HEALTH CARE

79. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE? Check YES or NO. Would Veteran require nursing home care and need adult day health care; and must meet any one of the following conditions:

    (1) The veteran has three or more Activities of Daily Living (ADL) dependencies.

    (2) The veteran has significant cognitive impairment.

    (3) The veteran has two ADL dependencies and two or more of the following conditions: (i) Seventy-five years old or older; (ii) High use of medical services, *i.e.,* three or more hospitalizations per calendar year, or 12 or more visits to an outpatient clinic or to an emergency evaluation unit per calendar year; (iii) Diagnosis of clinical depression; or (iv) Living alone in the community.

    (4) The veteran does not meet the criteria in 38 CFR 51.52, but nevertheless a licensed VA medical practitioner determines the veteran needs adult day health care services.

80. VETERAN APPROVED FOR ADULT DAY HEALTH CARE - Check YES or NO.

81. REMARKS - Enter any remarks regarding the Clinical Review section to include justification for a denial or approval with a DOM waiver for per diem.

82. SIGNATURE OF VA PHYSICIAN/APRN/PA - Enter Signature of VA Physician, or Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).

    NOTE: VA clinician signature in block 82 indicates approval of level of care recommended by SVH physician in block 41. However, if the VA Clinician do not agree with the SVH Physician level of care recommendation, then per diem is not approved and denial letter must be sent to the State Home with Appeal Rights.

83. DATE - Date of VA Physician, or APRN, or PA signature.