

Homeless Veterans and Health Care

A Resource Guide for Providers

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The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness.

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Preface

Health care providers who serve homeless veterans as part of their general clientele deal with complex health care issues and a bewildering array of resources intended for veterans.

This Resource Guide brings together the current information about these issues and resources in a format that will be useful to service providers, to homeless veterans and to others concerned about the health and welfare of veterans of our country's armed services.

The author is a veteran of another sort. Marsha McMurray-Avila was a direct service provider at Albuquerque Health Care for the Homeless, became the Executive Director of that fine agency, wrote the definitive *Organizing Health Services for Homeless People: A Practical Guide*, and now is the Program Coordinator for the National Health Care for the Homeless Council. This Resource Guide is evidence of Marsha's gift for assimilating, organizing and making accessible a huge amount of information from disparate sources. In preparing it, she has served our cause well.

Our cause is not simply improving the delivery of health services to homeless veterans. Our cause is creating a world of justice, where there will be no veterans because there will be no armed conflict, where there will be no homelessness because everyone will have homes, and where everyone will have ready access to health care. These are assuredly distant goals, but we begin to approach them when we care for those who are victimized by the injustices that we know today. This publication will help us do that better.

John Lozier
Executive Director
National Health Care for the Homeless Council

March 13, 2001

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Introduction

In spite of [a] long history of homelessness among veterans, the appearance of large numbers of them during the 1980s was not easy to understand. Since World War II, U.S. Veterans have been offered a broad range of special benefits, including educational assistance, home loan guaranties, pension and disability payments, and free health care. In fact, veterans consistently have higher median incomes, lower rates of poverty and unemployment, and are better educated than U.S. males in similar age groups.ⁱ Veterans should have been less vulnerable to homelessness than other Americans.

Robert Rosenheck, et al.
“Homeless Veterans”
*Homelessness in America*ⁱⁱ

Providers of health care services to people experiencing homelessness are well-aware of this apparent contradiction. Why are veterans who should have special benefits and services available to them from the Department of Veterans Affairs (VA) ending up on the streets of the country they served? Two core questions are raised by this incongruity: “Why did they become homeless?” and “Why aren’t VA services and benefits helping them get off the streets?”

Why are veterans homeless? Research has helped to illuminate the causes of veteran homelessness, pointing away from military service as a risk factor and towards the “usual suspects” of personal vulnerabilities related to physical and mental health, addictions, and social isolation, occurring within the structural context of lack of affordable housing and extreme poverty.

With regard to the second question of why available services and benefits don’t always create a path out of homelessness, there are several possible scenarios. Clearly, veterans with “other than honorable discharges” – also known as “bad paper” – would not have access to benefits and services from the VA. But what about those who are eligible who don’t take advantage of what’s available? Are they simply unaware of the resources? Are they aware, but too confused and frustrated by the process involved to apply? Are they actively avoiding contact with the large government institution of the VA? Or are the services not appropriate or adequate to meet their needs?

The answer, of course, is “all of the above.” Each individual veteran is different. Health care providers – whether involved in medical care, mental health/substance abuse services, social work, case management or outreach activities – need to understand those individual differences. Just as important is having a clear

picture of the complex range of services and benefits offered by the VA and community-based organizations, including eligibility requirements and how to facilitate access.

This document is designed to begin addressing these issues. Although it may also be of use to others in the field, it is primarily directed towards health care providers who serve homeless veterans as part of their general client population. It is not intended as a guide to best practices for setting up specific programs for homeless veterans, in that it does not include a comprehensive comparison of the various approaches to veterans' programs. Rather, this is presented as an introduction to what we have learned from research and practice about the needs of homeless veterans, plus current resources available to meet those needs, and some ideas for future collaboration. References are included for additional sources that can be consulted for more complete information in each of the following areas:

Chapter 1 – The Basics: Characteristics of homeless veterans

General knowledge about characteristics and numbers of veterans who are experiencing homelessness, including the circumstances and causes of that homelessness

Chapter 2 – Clinical Issues: What clinicians should know when treating homeless veterans

Special health conditions that may be encountered when serving homeless veterans, including: PTSD, Agent Orange, Gulf War Syndrome, and others

Chapter 3 – Eligibility Criteria: Eligibility for VA benefits and services

Discharge status required to be eligible for services, service-connected and nonservice-connected disabilities, working with Veterans Service Organizations (VSOs) to upgrade discharges and appeal denied claims

Chapter 4 – VA Health Programs: VA health care services for all eligible veterans

Mainstream VA health programs, priority groups and process for enrollment

Chapter 5 – VA Benefits: VA benefits for all eligible veterans

Disability compensation and disability pension

Chapter 6 – VA Homeless Programs: Services designed specifically for homeless veterans

Domiciliary Care for Homeless Veterans (DCHV), Health Care for Homeless Veterans (HCHV) including numerous program components, and resources for community-based organizations serving homeless veterans

Chapter 7 – Critical Access Issues: Obstacles to access faced by homeless veterans

Utilization of VA services by homeless veterans and common barriers to access

Chapter 8 – Non-VA Resources: Services for homeless veterans outside the VA system

Non-VA resources for veterans unable or unwilling to use VA services

Chapter 9 – Collaboration and Advocacy: Improving access to care for homeless veterans

Community collaborations with the VA and other organizations (CHALENG, Stand Downs, examples of HCH/VA collaborations) and national organizations involved in advocacy for homeless veterans

I

The Basics

Characteristics of homeless veterans

How many people experiencing homelessness are veterans?

In 1996, about 23% of people who were homeless on any one day were veterans, according to a 1999 Urban Institute studyⁱⁱⁱ funded by the Interagency Council on Homelessness which includes the Veterans' Administration. Homeless veterans are overwhelmingly male (98%), so the rate increases to 33% if only adult homeless men are considered. An earlier study using data from 1986-87 found that 40% of homeless men reported past military service, as compared with 34% in the general adult male population, making veterans 1.4 times more likely than nonveteran men to be homeless at that time.^{iv}

Of particular note, however, is the finding that homelessness does not affect all age groups of veterans equally. The 1987 data mentioned above showed a significantly greater likelihood of homelessness among veterans age 20 to 34 (79% of whom served in the post-Vietnam era, while only 7% served in combat) and age 45 to 54 (78% of whom served between the Korean and Vietnam eras, with 17% serving in combat) than among nonveterans of the same age in the general population. The most dramatic finding was that white veterans age 20 to 34 were 4.8 times more likely to be homeless than their nonveteran counterparts in the general population. In contrast, veterans in the 35 to 44 age group (most of whom served during the Vietnam era), or in the 55 to 64 and 65 and older age groups (those who served during the Korean or World War II eras) showed no greater risk of homelessness than nonveterans.

What are the differences between homeless people who are veterans and homeless people who are not veterans?

As seen below in Table 1,^v homeless male veterans are more likely than non-veteran homeless males to be white non-Hispanic (46% versus 34%) and less likely to be Hispanic or Native American (9% versus 26%). African Americans are almost equally represented among homeless veterans and non-veterans (45% versus 40%). Homeless veterans are generally an older population with 44% between the ages of 45 and 64, compared to only 20% of homeless non-veterans in that age category. And although the 35 to 44 age group is similar (44% for veterans versus 43% for non-veterans), the number of younger veterans age 18 to 35 is much less (10%) than for non-vets (37%). In addition, 85% of homeless veterans have completed high school or received a GED, compared to 56% of non-homeless veterans. The two groups are identical in marital status as far as being married at the time of the survey (7%). There the similarity ends. Thirty-three percent of homeless veterans have never been married, compared to 59% of homeless non-veterans. However, despite having been married more often, homeless veterans are also more likely to be divorced (38% versus 19%) or separated (19% versus 13%).

TABLE 1 – Comparison of Veterans and Non-Veterans in the Homeless Male Population

National Survey of Homeless Assistance Providers and Clients – Urban Institute (1999)

	Homeless Veterans (N=632)	Homeless Non-Veterans (N=1353)
Race/Ethnicity	%	%
White non-Hispanic	46	34
Black non-Hispanic	45	40
Hispanic	5	13
Native American	4	13
Other	1	1
Age	%	%
18-21	-	6
22-24	1	4
25-34	9	27
35-44	44	43
45-54	30	15
55-64	14	5
65+	2	-
Education	%	%
Less than high school	15	44
High school graduate/GED	40	34
More than high school	45	22
Marital Status	%	%
Never married	33	59
Married	7	7
Widowed	3	2
Divorced	38	19
Separated	19	13

Did most homeless veterans serve in Vietnam?

Although the Urban Institute study (see Table 2) found that almost half (47%) of homeless veterans served during the Vietnam Era (August 1964 through May 1975), not all of those actually served in “in country,” i.e., in the Vietnam war zone. (In the general population of all Vietnam Era veterans, 45% actually served in Vietnam where they may or may not have been exposed to combat duty.)

TABLE 2 – Period of Active Duty in the Armed Forces for Currently Homeless Veterans

National Survey of Homeless Assistance Providers and Clients – Urban Institute (1999)

Period of Active Duty*	N=676
August 1990 or later (Gulf War Era)	8%
September 1980 to July 1990	17%
May 1975 to August 1980	32%
August 1964 to April 1975 (Vietnam Era)	47%
February 1955 to July 1964	15%
June 1950 to January 1955 (Korean conflict)	4%
September 1940 to July 1947 (World War II)	1%
Any other time	1%

* Total does not equal 100%, since some individuals served in more than one period of active duty.

Only 15% of homeless veterans served before the Vietnam War (February 1955 to July 1964), while 49% served during the post-Vietnam Era (32% from May 1975 to August 1980 and 17 % from September 1980 to July 1990). One-third (33%) of all the homeless veterans surveyed reported being stationed in a war zone, and 28% were exposed to combat.

Does being a veteran put people at risk for becoming homeless?

Despite this common belief, there is actually little evidence that being a veteran leads to becoming homeless. Studies by Rosenheck and colleagues^{vi} have reviewed the experiences of homeless and non-homeless veterans, focusing on their exposure to war-zone service or combat, and subsequent prevalence of post-traumatic stress disorder (PTSD) which might serve as a precursor to homelessness. Their analysis resulted in the findings that:

1. Homeless veterans are ***much less likely*** than non-homeless veterans to have served in combat.
2. Homeless veterans are ***no more likely*** to be diagnosed with PTSD than non-homeless veterans.
3. The risk of homelessness is ***lower*** in veterans who served during wartime (the Vietnam Era, Korea or World War II) and ***higher*** in those veterans who served during the post-Vietnam Era and the peacetime era between the Korea and Vietnam conflicts.

After establishing that the veterans at greatest risk for homelessness were those who entered the military during the late Vietnam and post-Vietnam eras (during the wind-down phase of the Vietnam War and the initial period of the All Volunteer Force (AVF)), it was clear that combat service and PTSD could not explain the difference in risk. Researchers then had to look at other possible causes for this group's higher risk of homelessness by re-examining other previous studies.

Comparison of socioeconomic characteristics of post-Vietnam veterans and matched nonveterans was made using data from the 1987 Current Population Survey on employment, education, income, and marital status. Although no difference emerged between white veterans and white nonveterans, the data did show that African American veterans in the same age cohort actually had higher incomes, lower poverty and unemployment rates, and lower probability of living alone.^{vii}

Dramatic results regarding mental health and substance abuse status were drawn from the Epidemiological Catchment Area study, a five-city study of psychiatric illness in the U.S. White veterans from the post-Vietnam Era – the cohort shown to be at highest risk for homelessness – had psychiatric disorders and substance abuse disorders two to three times more prevalent than nonveterans, and rates of antisocial personality disorder that were five to six times as high. Differences were not quite as extreme among African American veterans, although rates of substance abuse were still almost twice as high among veterans aged 20 to 35 than among nonveterans.^{viii}

Additional information was drawn from a re-analysis of the 1987-88 National Vietnam Veterans Readjustment Study (NVVRS) to evaluate the relationship of military stressors, health status, and social adjustment factors to past homelessness among Vietnam era veterans.^{ix} This study found that:

1. Experiences ***prior*** to joining the military, especially adolescent conduct disorder (i.e., antisocial or delinquent behavior) and childhood physical and sexual abuse, had a stronger relationship to homelessness than actual military experiences.
2. Social isolation (e.g., being unmarried or having no one to talk to after returning from the military) had a ***stronger*** relationship with homelessness than did psychiatric disorders (psychiatric diagnosis, PTSD and substance abuse).

The question still remained as to why veterans in the late stages of the Vietnam era and beginnings of the post-draft All Volunteer Force had an increased vulnerability for later homelessness. One piece of evidence is that veterans were found to have more severe substance abuse problems than the general population, both during and subsequent to their military service.^x It was also discovered in 1981 that between 1976 and 1980 the Armed Forces Qualifying Test (AFQT) – a test of verbal and quantitative aptitude that is used to screen out recruits with low potential for success in the military – was misnormed, resulting in 300,000 low-aptitude “potentially ineligible” volunteers being inadvertently scored as qualified and entering the military.^{xi}

Rosenheck and colleagues concluded that “. . .in the cohort of veterans at greatest risk for homelessness, it is mental illness and substance abuse, rather than combat exposure or economic disadvantage, that are most strongly associated with increased risk for homelessness.”^{xii} They go on to emphasize, however, that they “do not believe that these risk factors ‘caused’ homelessness among the veterans, but rather that, with the severe recession of 1982, the declining availability of affordable housing during the 1980s, and the redistribution of wealth away from low-income Americans, these veterans were at greater risk for homelessness than those who had fewer vulnerabilities.”^{xiii}

None of this is meant to imply that PTSD is not a real problem for many homeless veterans. “PTSD is very important to treat, but it’s not an independent factor that makes people become homeless over and above poverty, social isolation, and other mental illnesses that accompany PTSD,” according to Dr. Rosenheck.^{xiv}

For more information on characteristics of homeless veterans, go to:

http://www.huduser.org/publications/pdf/home_tech/tchap-11.pdf

A chapter on homeless veterans is included in the National Survey of Homeless Assistance Providers and Clients (NSHAPC), a 1999 Urban Institute study for the Interagency Council on the Homeless, based on Census Bureau surveys of homeless service providers and clients in late 1996,

www.va.gov/health/homeless/

The VA’s website has information on homeless veterans, as well as links to other sources.

www.va.gov/vetstats/index.htm

The VA’s website for data on veterans.

www.nchv.org

The National Coalition for Homeless Veterans provides information on advocacy issues and links to other organizations serving homeless vets.

The Northeast Program Evaluation Center (NEPEC) at the VA Connecticut Healthcare System is responsible for a substantial portion of the research on homeless veterans that has been published, some of which is included here as references. Contact information for the Center is: Department of Veterans Affairs, Northeast Program Evaluation Center / 182, VA CT Healthcare System, West Haven, CT 06516; (203) 937-3850.

2 Clinical Issues

What clinicians should know when treating homeless veterans

What are the most common health problems of veterans who are homeless?

According to the 1999 Urban Institute study,^{xv} homeless veterans and non-veterans have the same incidence of acute health problems. Twenty-five percent of homeless veterans report having one or more acute infectious conditions, compared to 24% of homeless non-veterans, while 8% of both groups report one or more acute non-infectious conditions. However, 52% of homeless veterans report having one or more chronic health conditions, compared to 44% of non-veterans who are homeless. The most common medical conditions reported by homeless veterans include arthritis, rheumatism or other joint problems (32%) and high blood pressure (23%). Possibly because of their younger average age, the rates for non-veterans are lower for both arthritis, rheumatism and other joint problems (21%) and for high blood pressure (12%).

The incidence of alcohol, drug, or mental health (ADM) problems was also found to be similar for veterans and non-veterans experiencing homelessness in the Urban Institute study. The majority of both groups have experienced past-month ADM problems (76% and 68% respectively), with alcohol difficulties being the most frequently reported (49% and 43%). When the time frame was expanded to the previous year, 58% of veterans and 53% of non-veterans reported an alcohol-related problem. The corresponding lifetime rates are 77% and 70% respectively. Among homeless males overall, 93% of veterans and 88% of non-veterans reported an ADM problem at some point in their lives.

An analysis of 1987 Urban Institute data and two single-city studies conducted in 1986 also found no physical health differences between veterans and non-veterans, nor any consistent differences across studies regarding veterans' and non-veterans' past hospitalization for psychiatric or substance abuse problems or suicide attempts.^{xvi}

However, the data is still not definitive enough to state unequivocally that there are no differences in the health status of homeless veteran and non-veteran males. Given the inconsistent research findings, Rosenheck and colleagues comment that "[t]here is some evidence that quite apart from differences explained by age, homeless veterans may be in poorer health than non-veterans and have somewhat more severe problems with alcohol, but in general, their service needs are not substantially different from those of other homeless men."^{xvii}

Although female homeless veterans have higher rates of psychiatric illness than their male counterparts (52% versus 41%) and are less likely to have a substance use disorder (43% versus 72%), they have not been found to differ in health status from homeless women who are not veterans.^{xviii}

What special health problems might homeless veterans face?

Despite the lack of research data showing significant differences in the health of homeless veterans and non-veterans, health care providers still need to be aware of military experiences that may have exposed their patients to specific health conditions.

Any veteran who has served in combat, been a prisoner of war or dealt with casualties from combat may be affected by post-traumatic stress disorder (PTSD). Veterans who served in Vietnam may have been exposed to the herbicide Agent Orange, considered to be the cause of numerous health conditions. Veterans who served in the Persian Gulf may be experiencing “Gulf War Syndrome” which manifests as multiple unexplained illnesses. Veterans who served in Korea may have lasting effects from cold injuries. Veterans from several eras were exposed to ionizing radiation. And there is evidence that veterans have a higher prevalence of hepatitis C infection.

Clinicians encountering veterans in specialized clinics for the homeless, in outreach programs, and in hospital emergency rooms should take a careful military service history. An accurate and empathic review of combat history is as important in the treatment of homeless combat veterans as it is in the treatment of their domiciled counterparts in the general population.^{xix}

Rosenheck, Leda and Gallup
“Combat Stress, Psychosocial Adjustment, and
Service Use Among Homeless Vietnam Veterans”
Hospital and Community Psychiatry

To facilitate the process of remembering which questions to ask, the VA has produced and distributed a two-sided laminated card with specific questions that care providers should ask of their patients who are veterans (see Appendix A).

The following sections address each of the above-mentioned health conditions in more detail.

Post-Traumatic Stress Disorder (PTSD)

War is a life threatening experience that involves witnessing and engaging in terrifying and gruesome acts of violence....The trauma of war is the shocking confrontation with death, devastation, and violence. It is normal for human beings to react to war's psychic trauma with feelings of fear, anger, grief, and horror, as well as emotional numbness and disbelief.

We know from numerous research studies that the more prolonged, extensive, and horrifying a soldier's or sailor's exposure to war trauma, the more likely that she or he will become emotionally worn down and exhausted – this happens to even the strongest and healthiest of individuals, and often it is precisely these exemplary soldiers who are the most psychologically disturbed by war because they are able to endure so much of it with such courage....

So it is no surprise that when military personnel have severe difficulty getting over the trauma of war, their psychological difficulties have been described as “soldier's heart” (in the Civil War), or “shell shock” (in World War I), or “combat fatigue” (in World War II). After World War II, psychiatrists realized that these problems usually were not an inborn “mental illness” like schizophrenia or manic depressive illness, but were a different form of psychological dis-ease that resulted from too much war trauma: “traumatic war neurosis” or “post-traumatic stress disorder” (PTSD). Most war veterans are troubled by war memories, but were fortunate enough either not to have “too much” trauma to recover from or to have immediate and lasting help from family, friends, and spiritual and psychological counselors so that the memories became “livable.”

National Center for PTSD
www.ncptsd.org

Unless otherwise noted, the following information is taken directly from the website of the National Center for PTSD at www.ncptsd.org

What is post-traumatic stress disorder (PTSD)?

Post-Traumatic Stress Disorder, or PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.

(See Appendix B for the DSM-IV diagnostic description of PTSD.)

What are the symptoms of PTSD?

Most people who are exposed to a traumatic, stressful event experience some of the symptoms of PTSD in the days and weeks following exposure, but the symptoms generally decrease over time and eventually disappear. However, about 8% of men and 20% of women go on to develop PTSD, and roughly 30% of these individuals develop a chronic form that persists throughout their lifetimes.

PTSD symptoms are described as:

- **Unwanted distressing memories or a feeling of reliving traumatic experiences (flashbacks)**
- **Nightmares and difficulty falling or staying asleep restfully**
- **Bodily stress and tension, especially when reminded of traumatic experiences**
- **Loss of interest in activities and difficulty in concentrating on activities or projects**
- **Detachment or withdrawal from emotional involvement in relationships**
- **Difficulty feeling or expressing emotions other than irritability or frustration**
- **Feeling like there is no future or their lives will be cut short by an untimely death**
- **Feeling jumpy, on-edge, and easily startled**
- **Feeling constantly unsafe and unable to let down their guard (hyper-vigilant)**

The symptoms generally fall into three clusters associated with PTSD:

1. Re-experiencing of the traumatic event:
 - Recurring nightmares
 - Intrusive daydreams or flashbacks
 - Dissociative experiences
 - Intensification of symptoms on exposure to reminders of the event
2. Avoidance or numbing:
 - Efforts to avoid thoughts, feelings, activities, or situations associated with the trauma
 - Feelings of detachment or alienation
 - Inability to have loving feelings
3. Hyperarousal:
 - Exaggerated startle response
 - Insomnia and other sleep disturbances
 - Irritability or outbursts of anger
 - Physiological reactions to exposure to reminders of the event

The course of chronic PTSD usually involves periods of symptom increase followed by remission or decrease, although for some individuals symptoms may be unremitting and severe. Some older veterans who report a lifetime of only mild symptoms have experienced significant increases following retirement, severe medical illness in themselves or their spouses, or reminders of their military service such as reunions or media broadcasts of the anniversaries of war events.

Psychiatric disorders commonly co-occurring with PTSD include: depression, alcohol/substance abuse, panic disorder, and other anxiety disorders. Although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse.

What are the physical consequences associated with PTSD?

PTSD is associated with a number of distinctive neurobiological and physiological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. Both of these brain structures are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response.

Psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous system, increased sensitivity of the startle reflex, and sleep abnormalities.

People with PTSD tend to have abnormal levels of key hormones involved in response to stress. Thyroid function seems to be enhanced in people with PTSD. Some studies have shown that cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal. People with PTSD also continue to produce higher than normal levels of natural opiates after the trauma has passed. An important finding is that the neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression; also, the distinctive profile associated with PTSD is seen in individuals who have both PTSD and depression.

PTSD is associated with increased likelihood of co-occurring psychiatric disorders. In a large-scale study, 88 percent of men and 79 percent of women with PTSD met criteria for another psychiatric disorder. The co-occurring disorders most prevalent for men with PTSD were alcohol abuse or dependence (51.9%), major depressive episode (47.9%), conduct disorder (43.3%), and drug abuse and dependence (34.5%). The disorders most frequently comorbid with PTSD among women were major depressive disorder (48.5%), simple phobia (29%), social phobia (28.4%) and alcohol abuse/dependence (27.9%).

Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, or discomfort in other parts of the body are common in people with PTSD. Often, medical doctors treat the symptoms without being aware that they stem from PTSD.

How is PTSD assessed and treated?

In recent years a great deal of research has been aimed at development and testing of reliable assessment tools. It is generally thought that the best way to diagnose PTSD – or any psychiatric disorder, for that matter – is to combine findings from structured interviews and questionnaires with physiological assessments. PTSD is treated by a variety of forms of psychotherapy and drug therapy. A multi-method approach is especially helpful to address concerns that some patients might be either denying or exaggerating their symptoms. There is no definitive treatment, and no cure, but some treatments appear to be quite promising and research into improved treatments is taking place constantly.

Treatment for PTSD typically begins with a detailed evaluation, and development of a treatment plan that meets the unique needs of the survivor. Generally, PTSD-specific treatment is begun only when the survivor is safely removed from a crisis situation. For instance, if currently exposed to trauma (such as by ongoing domestic or community violence, abuse, or homelessness), severely depressed or suicidal, experiencing extreme panic or disorganized thinking, or in need of drug or alcohol detoxification, addressing these crisis problems becomes part of the first treatment phase.

What therapeutic approaches are commonly used to treat PTSD?

- **Cognitive-behavioral therapy (CBT)** involves working with cognitions to change emotions, thoughts, and behaviors. *Exposure therapy*, is one form of CBT unique to trauma treatment which uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context, to help the survivor face and gain control of the fear and distress that was overwhelming in the trauma. In some cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas it is preferable to work gradually up to the most severe trauma by using relaxation techniques and either starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization").

Along with exposure, CBT for trauma includes learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts ("cognitive restructuring"), managing anger, preparing for stress reactions ("stress inoculation"), handling future trauma symptoms, as well as addressing urges to use alcohol or drugs when they occur ("relapse prevention"), and communicating and relating effectively with people ("social skills" or marital therapy).

- **Pharmacotherapy** (medication) can reduce the anxiety, depression, and insomnia often experienced with PTSD, and in some cases may help relieve the distress and emotional numbness caused by trauma memories. Several kinds of antidepressant drugs have achieved improvement in most (but not all) clinical trials, and some other classes of drugs have shown promise. At this time no particular drug has emerged as a definitive treatment for PTSD, although medication is clearly useful for the symptom relief that makes it possible for survivors to participate in psychotherapy.
- **Eye Movement Desensitization and Reprocessing (EMDR)** is a relatively new treatment of traumatic memories which involves elements of exposure therapy and cognitive behavioral therapy, combined with techniques (eye movements, hand taps, sounds) which create an alteration of attention back and forth across the person's midline. While the theory and research are still evolving with this form of treatment, there is some evidence that the therapeutic element unique to EMDR, attentional alteration, may facilitate accessing and processing traumatic material.
- **Group treatment** is often an ideal therapeutic setting because trauma survivors are able to risk sharing traumatic material with the safety, cohesion, and empathy provided by other survivors. As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share coping of trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives.
- **Brief psychodynamic** psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, empathic, compassionate and non-judgmental therapist, the survivor achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and more successfully deals with the intense emotions that emerge during therapy. The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms.

How common is PTSD in veterans?

PTSD is not a new disorder. There are written accounts of similar symptoms that go back to ancient times, and there is clear documentation in the historical medical literature starting with the Civil War, where a PTSD-like disorder was known as "Da Costa's Syndrome." There are particularly good descriptions of post-traumatic stress symptoms in the medical literature on combat veterans of World War II and on Holocaust survivors.

Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Study estimated in 1988 that the prevalence of PTSD in that group was 15.2% at that time, and that 30% had experienced the disorder at some point since returning from Vietnam.

PTSD has subsequently been observed in all veteran populations that have been studied, including World War II, Korean conflict, and Persian Gulf, and in United Nations peacekeeping forces deployed to other war zones around the world. PTSD also appears in military veterans in other countries with remarkably similar findings — that is, Australian Vietnam veterans experience much the same symptoms as American Vietnam veterans.

About 30% of the men and women who have spent time in war zones experience PTSD. An additional 20% to 25% have had partial PTSD at some point in their lives. Thus, more than half of all male Vietnam veterans and almost half of all female Vietnam veterans have experienced "clinically serious stress reaction symptoms." PTSD has also been detected among veterans of the Gulf War, with some estimates running as high as 8%.

PTSD is not only a problem for veterans, however. Although there are unique cultural- and gender-based aspects to the disorder, it occurs in both men and women, adults and children, Western and non-Western cultural groups, and all socioeconomic strata. A national study of American civilians conducted in 1995 estimated that the lifetime prevalence of PTSD was 5% in men and 10% in women.

How many homeless veterans are affected by PTSD?

According to the National Coalition for Homeless Veterans, about one quarter of homeless veterans who served during the Vietnam era have full or partial symptoms of PTSD.^{xx} The percentages are even higher for homeless veterans who are mentally ill, with some studies showing as many as 43% have "evidence of combat stress."^{xxi}

One of the difficulties in assessing or diagnosing PTSD in people who are experiencing homelessness is that many of the symptoms of PTSD can also be the result of the homeless experience. The four DSM-III-R diagnostic criteria for PTSD are: evidence of a traumatic stressor; experiences of reliving the trauma; numbed emotions or lack of involvement in significant activities; and evidence of hyperarousal, sleep disturbance, or other specified symptoms.^{xxii} Researchers for the VA's Homeless Chronically Mentally Ill (HCMI) program found that "Field experience with the homeless, however, suggested that homelessness itself frequently produces positive responses to questions about numbing and lack of involvement and hyperarousal and sleep disturbance. Since these responses could not be clearly attributed to past combat experiences, only experiences of reliving combat-related trauma were used to assess combat stress."^{xxiii}

These researchers reported in 1992 that the homeless Vietnam veterans in the HCMI program who showed evidence of combat stress also had more severe psychiatric and substance abuse problems than those without combat stress. Levels of social adjustment difficulties were the same for those with and those without combat stress. However, when all homeless Vietnam veterans were compared to Vietnam veterans in the general population, dramatic differences in social adjustment emerged, suggesting that "social adjustment problems that might be specifically associated with combat stress are obscured among homeless veterans by their generally abysmal life circumstances."^{xxiv}

Although precise comparisons cannot be made between the proportion of veterans with combat stress in the HCMV Veterans Program and prevalence estimates of PTSD in the general population of Vietnam veterans, our data indicate that a sizable proportion of homeless mentally ill Vietnam veterans suffer combat stress that is accompanied by serious psychiatric and substance abuse problems as well as by severe social and vocational dysfunction. Homeless mentally ill Vietnam veterans appear to be significantly underserved and in need of specialized services directed at both their combat-related psychiatric problems and their severe housing, financial, and social difficulties.^{xxxv}

Rosenheck, Leda and Gallup
“Combat Stress, Psychosocial Adjustment, and
Service Use Among Homeless Vietnam Veterans”
Hospital and Community Psychiatry

Do culture and race affect risk for PTSD in veterans?

In the study of HCMV participants referenced above, the prevalence of combat stress was significantly higher among non-whites (48.6%) than among whites (39.5%) which is consistent with findings from the 1988 National Vietnam Veterans Readjustment Study (NVVRS) which showed that African American or Hispanic veterans were more likely to meet diagnostic criteria for PTSD than white veterans.

As a follow-up to the NVVRS, an additional study was conducted to include other minority veterans. The Matsunaga Vietnam Veterans Project included two parallel studies – the American Indian Vietnam Veterans Project and the Hawaii Vietnam Veterans Project. According to the National Center for PTSD, the Matsunaga Study’s key finding was that exposure to war zone stress and other military danger places veterans at risk for PTSD several decades after military service. Native Hawaiian and American Indian Vietnam in-country veterans had relatively high levels of exposure to war zone stress, and later PTSD. Caucasian and Japanese American veterans tended to have somewhat lower levels of exposure to war zone stress and later PTSD. The unique cultural traditions, society, and family experiences of each different ethnocultural group played an important role in the veteran’s homecoming and readjustment after Vietnam, but do not appear to either cause or prevent PTSD.

American Indian Vietnam in-country veterans reported the most severe problems of any ethnocultural group in the NVVRS or Matsunaga Project. About one in three American Indian in-country Vietnam veterans suffered from full or partial PTSD at the time of the study, a quarter century or more after the war. More than two in three American Indian in-country Vietnam veterans suffered from full or partial PTSD at the time. These PTSD prevalences are very high, more than twice as high as for White or Japanese American Vietnam veterans. The Northern Plains veterans were by far the most likely of any study group, including Southwest tribal veterans, to have been verbally hostile recently, to have been homeless or vagrant, to have been divorced once or several times and to have had problems as a parent. PTSD explains much of these interpersonal problems. In addition, the Northern Plains veterans had great difficulty in rejoining the very tightly-knit extended family/community of their tribe after the war. For example, only one in seven of these veterans had participated in a traditional healing ceremony, compared to one in two Southwest Indian veterans.

American Indian Vietnam veterans also reported the poorest physical health and the highest level of use of medical care of any NVVRS or Matsunaga Project group. This may be partly due to chronic alcohol overuse, which often is associated with smoking and poor health habits. However, PTSD also plays a role in poor physical health. PTSD symptoms such as restlessness, tension, irritability, anxiety, and poor sleep are exhausting and hard on the body. Culturally, it also may be more acceptable to disclose somatic problems and pains to family or medical providers, than to admit emotional distress. Physical illness more often results in sympathy and concern, while emotional distress may be mistakenly viewed (by the veteran, his family and community, or the medical provider) as a sign of weakness or lack of character.

Where can veterans get help for PTSD?

As indicated by the research studies above, eligible homeless veterans with PTSD who also suffer from severe mental illness may be served by the HCMI program. For veterans who have PTSD either without psychiatric co-morbidities or only to an extent that does not prevent program participation, the VA operates a network of 205 Vet Centers around the country which offer Readjustment Counseling Services (RCS) consisting of psychotherapy and individual, group, and/or family counseling for PTSD.

Originally created for the use of Vietnam veterans (with readjustment concerns or PTSD), by 1991 the Vet Centers were opened to all combat veterans, including Gulf War veterans (Public Law 102-25). Vet Center services are especially appropriate for those veterans who prefer to work with therapists or counselors who themselves are war veterans, who need services in a less institutional setting, or where the Vet Center location may be more accessible. For more information on which veterans are eligible for Readjustment Counseling Services, see the section on Vet Centers below in Chapter 4. For a listing of Vet Centers throughout the country, see Appendix B or go to www.va.gov/station/VetCenter/Telephone.htm.

There are also a few VA medical centers that offer intensive in-patient care. If this treatment is needed, ask the nearest Vet Center to help arrange admission for the veteran. Sometimes the VA will pay for treatment through a local mental health professional if services through the nearest VA are not readily available. To apply for this "fee basis" care, contact the nearest VA medical center.

PTSD is recognized as a service-related condition, and the VA will provide medical care, and in some cases compensation. Under current VA rules, veterans can be paid compensation for PTSD if they have a clear diagnosis of the condition, evidence that an in-service stressful event occurred and medical evidence that the "stressor" is linked to the PTSD. Once the VA agrees that the veteran's PTSD is service-connected, it will then decide how seriously the condition impairs their ability to work. (See Appendix B for the "General Rating Formula for Mental Disorders" excerpted from 38 C.F.R. 4.130.) For additional questions on treatment resources, as well as more information on research and links to other sites about PTSD, the National Center for PTSD has an extensive website at www.ncptsd.org.

The following helpful information is excerpted from the Vietnam Veterans of America (VVA) Guide on how to apply for disability based on PTSD. The complete Guide is available from VVA (see address and phone in Appendix C) or on their website at www.vva.org.

TABLE 3 – VVA’s GUIDE ON PTSD (excerpt)

STEP 3: GET A DIAGNOSIS

You cannot get benefits from the VA for PTSD if you do not have a clear diagnosis of PTSD. That diagnosis should come from a mental health professional (psychiatrist, psychologist, social worker or therapist). You, your mother and your lawyer may know you have PTSD but the VA will not pay you unless a medical professional can firmly diagnose you as suffering from PTSD and can link the PTSD to a stressful event during your military service.

If at all possible, work with a private mental health professional who has had experience with PTSD patients and understands the requirements for a clear diagnosis and who is willing to write a detailed report for you that explains exactly the reasons he or she concludes you have PTSD.

Frequently, veterans with PTSD may have other diagnoses: for example, personality disorder or substance abuse. It is very important that your doctor explain how your current diagnosis of PTSD relates to these other disorders. If alcohol or drug abuse was "self-medication" to lessen the symptoms of PTSD, that should be stated.

You can expect the VA to contact you for evidence or for permission to write to your doctor for your medical records. Your response to any VA request for evidence should be made only after consulting with your representative.

The VA ordinarily schedules you for an examination by one of its doctor at a VA hospital or clinic. This "C&P exam" is intended to confirm a diagnosis of PTSD. If you bring a copy of your doctor's report with you, it will be easier for the VA doctor to complete the exam.

If you do not already have a private doctor's report, you should expect the VA doctor to ask many questions about what symptoms you have, when you began to have them, how often and how long you have had them. Some of the hardest questions will be about the stressful experience you had. You will need to be able to describe in detail (and sometimes painful detail) exactly what you experienced. You might also be asked to take a written, standardized test.

The VA doctor prepares a written report that is sent to the VA Regional Office (VARO) in about a month.

STEP 4: GET EVIDENCE OF STRESSOR

To win a PTSD-based claim, you need (1) a diagnosis of PTSD *and* (2) evidence of a stressful event during your military service. Even if you convince 10 VA and 10 private psychiatrists that you have PTSD, the VARO can still deny your claim if it does not accept your evidence about the stressful event that caused the PTSD.

The stressor you experienced needs to be documented. If your stressor was related to combat while engaged in action with the enemy, your testimony alone should convince the VA that you experienced the event. The VA should not even question your statement if you had a combat Military Occupational Skill (MOS) or you received a Purple Heart or other award indicating combat service.

On the other hand, if you did not have a combat MOS and simply state that you were often under mortar and rocket attacks, the VA may simply say that your experience was not stressful enough to have caused PTSD since nearly everyone stationed in Vietnam came under such attacks. If, however, you were next to a buddy who was killed or injured, the fact of the death or injury is something that can be confirmed.

If you are a Vietnam vet and you provide the VA with enough details about stressful events in your service, the VA will contact the U.S. Army and Joint Services Environmental Support Group and ask it to review records of the Vietnam war to try to corroborate your experiences. Your representative should be able to show you the *Guide for the Preparation of PTSD Research Requests* that the Support Group offers to reps to help them make a request that the Support Group can work with.

Agent Orange

Unless otherwise noted, the following information is taken directly from the VA's Environmental Agents Service (EAS), either in their May 2000 or August 2000 issue of "Agent Orange Review" or their September 1999 publication "Agent Orange: Information for Veterans Who Served in Vietnam," all of which are posted in PDF format at www.va.gov/agentorange/

What is Agent Orange?

Agent Orange was a herbicide used in Vietnam to kill unwanted plants and to remove leaves from trees. The name, "Agent Orange," came from the orange stripe on the 55-gallon drums in which it was stored. Other herbicides, including Agent White and Agent Blue, were also used in Vietnam to a much lesser extent. One of the chemicals in Agent Orange contained traces of TCDD or dioxin, which recent studies have linked to a number of types of cancer and other disorders.

Fifteen different herbicides were shipped to and used in Vietnam between January 1962 and September 1971, but over 80% of the herbicide sprayed in Vietnam was Agent Orange, which was used between January 1965 and April 1970. Before the end of the spraying in 1971, more than 20 million gallons of herbicides were sprayed over 6 million acres, some of which were sprayed more than once. Spraying occurred in all four military zones of Vietnam.

Under the law, veterans who served in Vietnam between 1962 and 1975 (including those who visited Vietnam even briefly or served in the waters just offshore), and who have a disease that VA recognizes as being associated with Agent Orange, are presumed to have been exposed to Agent Orange. These veterans are eligible for service-connected compensation (see Chapter 5 for more on compensation) based on their service, if they have one of the diseases on the list of "diseases associated with exposure to certain herbicide agents" (see Table 3 below). The VA updates this list regularly based to a large extent on reports from the National Academy of Sciences, an independent research and education institution.

In addition, children of Vietnam veterans suffering from the serious birth defect spina bifida, which has been linked to the veterans' exposure to Agent Orange, are now eligible for benefits including health care, monthly disability compensation, and vocational rehabilitation.

Under Section 102, Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, the VA is required to furnish hospital care and medical services, and may furnish nursing home care to veterans exposed to herbicides in Vietnam. There are some restrictions. The VA cannot provide such care for a (1) disability which the VA determines did not result from exposure to Agent Orange, or (2) a disease for which the National Academy of Sciences (NAS) has determined there is "limited/suggestive evidence of no association" between occurrence of the disease and exposure to a herbicide agent. The 1998 update, released by the NAS in February 1999, identified the following conditions as "limited/suggestive evidence of no association": gastrointestinal tumors (stomach cancer, pancreatic cancer, colon cancer, rectal cancer), and brain tumors.

The VA pays disability compensation to Vietnam veterans with injuries or illnesses incurred in or aggravated by their military service. Veterans do not have to prove that Agent Orange caused their medical problems to be eligible for compensation. Rather, the VA must determine that the disability is "service-connected." A Veterans Benefits Counselor, at a VA medical center or regional office, can explain the compensation program in greater detail and assist veterans who need help in applying. For more information about the VA disability compensation program, call toll-free: 1-800-827-1000. (Also see Chapters 3 and 5 below.)

TABLE 4

Diseases associated with exposure to Agent Orange
(as of November 2000)

These are the diseases that VA currently presumes resulted from exposure to herbicides like Agent Orange. The law requires that some of these diseases be at least 10% disabling under VA's rating regulations within a deadline that began to run the day you left Vietnam. If there is a deadline, it is listed in parentheses after the name of the disease.

- **Chloracne** or other acneform disease consistent with chloracne – A skin condition that looks like common forms of acne seen with teenagers. The first sign of chloracne may be excessive oiliness of the skin. This is accompanied or followed by numerous blackheads. In mild cases, the blackheads may be limited to the areas around the eyes extending to the temples. In more severe cases, blackheads may appear in many places, especially over the cheek bone and other facial areas, behind the ears, and along the arms. (Must occur within one year of exposure to Agent Orange.)
- **Hodgkin's disease** – A malignant lymphoma (cancer) characterized by progressive enlargement of the lymph nodes, liver, and spleen, and by progressive anemia.
- **Multiple myeloma** – A cancer of specific bone marrow cells that is characterized by bone marrow tumors in various bones of the body.
- **Non-Hodgkin's lymphoma** – A group of malignant tumors (cancer) that affect the lymph glands and other lymphatic tissue. These tumors are relatively rare compared to other types of cancer, and although survival rates have improved during the past two decades, these diseases tend to be fatal. The common factor is the absence of the giant Reed-Sternberg cells which distinguish this cancer from Hodgkin's disease.
- **Acute and subacute peripheral neuropathy** – A nervous system condition that causes numbness, tingling, and muscle weakness. This condition affects only the peripheral nervous system, that is, only the nervous system outside the brain and spinal cord. Only the transient acute (short-term) and subacute form of this condition (not the chronic persistent form) has been associated with herbicide exposure. (For purposes of this section, the term acute and subacute peripheral neuropathy means temporary peripheral neuropathy that appears within one year of exposure to an herbicide agent and resolves within two years of the date of onset.)
- **Porphyria cutanea tarda** – A disorder characterized by liver dysfunction and by thinning and blistering of the skin in sun-exposed areas. (Must occur within one year of exposure to Agent Orange.)
- **Prostate cancer** – Cancer of the prostate; one of the most common cancers among men.
- **Respiratory cancers** – Cancer of the lung, bronchus, larynx, or trachea. (Must occur within 30 years of exposure to Agent Orange.)
- **Soft-tissue sarcoma** – A group of different types of malignant tumors (cancer) that arise from body tissues such as muscle, fat, blood and lymph vessels and connective tissues (not in hard tissue such as bone or cartilage). These cancers are in the soft tissue that occur within and between organs. (Does not include osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma.)
- **Spina bifida (in the children of Vietnam veterans)** – A neural tube birth defect that results from the failure of the bony portion of the spine to close properly in the developing fetus during early pregnancy. (Spina bifida occulta is excluded.)
- **Type II diabetes** – Also known as adult onset diabetes, this was added in November 2000, based on recent research.

What evidence is needed to support a disability claim for Agent Orange exposure?

In an Agent Orange-based claim by a Vietnam veteran for service-connected benefits, VA requires:

1. a medical diagnosis of a disease which VA recognizes as being associated with Agent Orange (see list);
2. competent evidence of service in Vietnam or offshore in the adjacent waters; and
3. competent medical evidence that the disease began within the deadline (if any).

What if the veteran served in Vietnam and has a disease not on the VA's list?

If the veteran served in Vietnam and believes that he or she has a disease caused by herbicide exposure, but that disease is not on VA's list of diseases associated with herbicides like Agent Orange, it is still possible to apply for service-connection. Such a veteran needs to establish entitlement to service connection on a "direct" (rather than "presumptive") basis. In these cases, the VA requires:

1. competent medical evidence of a current disability;
2. competent evidence of exposure to an herbicide in Vietnam; and
3. competent medical evidence of a nexus (causal relationship) between the herbicide exposure and the current disability.

What if the veteran was exposed to an herbicide outside Vietnam?

Herbicides were used by the U.S. military to defoliate military facilities in the U.S. and in other countries as far back as the 1950s. Even if the veteran did not serve in Vietnam, he or she can still apply for service-connected benefits if exposed to an herbicide while in the military which he or she believes caused the disease or injury. If the veteran has a **disease which is on the list** of diseases which the VA recognizes as being associated with Agent Orange, the VA requires:

1. a medical diagnosis of a disease which the VA recognizes as being associated with Agent Orange;
2. competent evidence of exposure to a chemical contained in one of the herbicides used in Vietnam (2,4-D; 2,4,5-T and its contaminant TCDD; cacodylic acid; or picloram); and
3. competent medical evidence that the disease began within the deadline for that disease (if any).

If the veteran has a **disease which is not on the list** of diseases which the VA recognizes as being associated with Agent Orange, the VA requires:

1. competent medical evidence of a current disability;
2. competent evidence of exposure to an herbicide during military service; and
3. competent medical evidence of a nexus (causal relationship) between the herbicide exposure and the current disability.

The National Veterans Legal Services Program (NVLSP) recently noted that the VA has acknowledged the possibility that some veterans who served in Korea during 1968 and 1969 may have been exposed to Agent Orange, and thus promulgated a directive to offer those veterans the same Agent Orange Registry examination currently provided to Vietnam vets.

"At the present time, veterans who served in Korea are not offered additional health care and compensation benefits based upon a presumption of service-connection due to exposure to herbicides like Agent Orange and the contaminant dioxin. However, veterans who can establish that they were exposed to herbicides during military service and that it is 'as likely as not' that a present illness is related to that exposure can meet the criteria for service-connected benefits. In most cases the veteran will need to prove exposure and submit an opinion of a medical expert linking the exposure to the current illness."^{xxvi}

What if the veteran decides not to file a claim for compensation?

Even veterans who decide not to file a claim for VA compensation based on Agent Orange can still get a free physical examination at the nearest VA Medical Center. This is called the Agent Orange Registry Exam. This exam consists of four parts: an exposure history, a medical history, laboratory tests and a physical exam of those body systems most commonly affected by toxic chemicals. This exam might detect diseases which can be treated more effectively the earlier they are diagnosed. They may also be entitled to free ongoing medical treatment at a VA medical facility.

Where can veterans get help with Agent Orange health problems or questions?

Vietnam veterans who are concerned about possible long-term health effects of Agent Orange exposure should contact the nearest VA medical center and request an Agent Orange Registry health examination. At each VA medical center there is a “Registry Physician” responsible for the conduct of Agent Orange Registry exams and an “Agent Orange Registry Coordinator” who facilitates the program. Over 300,000 Vietnam veterans have already participated in this program.

Vietnam veterans who need medical treatment for conditions that may be related to their exposure to Agent Orange or other herbicides used in Vietnam should contact the nearest VA medical center for eligibility information and possible medical treatment. Vietnam veterans who encounter difficulties at a VA medical center should contact the “patient advocate” at that facility for assistance in resolving the problem.

Vietnam veterans with illnesses that were incurred in or aggravated by exposure to Agent Orange or other aspects of military service should contact a VA veterans benefits counselor at the nearest VA regional office or health care facility and apply for disability compensation. The counselors have information about the wide range of benefit programs administered by VA. The national toll-free number is 1-800-827-1000.

Representative of veterans service organizations (VSOs) are very helpful to Vietnam veterans seeking disability compensation. A directory of VSOs that are chartered by Congress and/or recognized by the VA for Claim Representation can be found at www.va.gov/vso/default.asp or see an abbreviated list of VSOs in Appendix C. Vietnam Veterans of America (VVA) is especially informed about changes or updates in Agent Orange benefits, and offer a special VVA Guide on Agent Orange that is available by contacting them at the address or phone in Appendix C. It is also available on their website at www.vva.org or by e-mailing them at veteransbenefits@vva.org.

Vietnam veterans with children who have spina bifida should contact the nearest VA regional office by calling toll-free: 1-800-827-1000. Additional information on spina bifida is available from the Spina Bifida Association of America at 4590 MacArthur Blvd., Suite 250, Washington, DC 20007-4226; toll-free telephone 1-800-621-3141; e-mail address: [spinabifda@aol.com](mailto:spinabifida@aol.com); and web site: www.sbaa.org

The “Agent Orange Review” newsletter, prepared by the VA Environmental Agents Service (EAS), provides updated information about federal government studies and activities related to Agent Orange and the Vietnam experience (available at www.va.gov/agentorange/ or by contacting the EAS (131), Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (202) 273-8580).

Brief fact sheets on Agent Orange, prepared and updated by the VA EAS, are available from the EAS office listed above, or at VA medical centers. These fact sheets include information on Agent Orange in general, a class action lawsuit, the Agent Orange Registry, health care eligibility, disability compensation, research issues, and descriptions of each of the diseases associated with Agent Orange exposure.

Gulf War Syndrome

Within a year of the end of Operation Desert Storm, thousands of American Gulf War veterans began to report that they were suffering from a number of medical problems: short and long-term memory loss; severe fatigue; chronic muscle and joint pain; gastrointestinal disorders; and, frequently, severe rashes. The press coined the term “Gulf War Syndrome” to describe the undiagnosed malady.^{xxvii}

There is currently a significant amount of controversy over the causes of Gulf War illnesses, the process by which research is being conducted (or not conducted), and the perceived lack of responsiveness to disability claims by Gulf War veterans on the part of the VA.

Even with an extremely high rejection rate of 73% for Gulf War veterans’ claims related to “undiagnosed illnesses,” these veterans still have the highest number of service-connected disabilities per veteran by war. Gulf War veterans average 3.26 service-connected disabilities per veteran, compared to the next highest of 2.76 per Vietnam veterans.

The information reproduced for the section below comes directly from the VA’s website and therefore represents their position. Alternative views regarding causes of Gulf War illnesses, as well as criticism of current research can be obtained from a variety of sources. Two references are mentioned here; additional resources regarding Gulf War veterans and Gulf War illnesses can be found in Appendix D.

- The National Gulf War Resource Center released a report on January 17, 2001, entitled “Uncounted Casualties: America’s Ailing Gulf War Veterans – A Special Report” that is available from their website at www.ngwrc.org or by contacting their office at (800) 882-1316 x162. Their website also includes links to numerous other organizations and sources.
- The International Action Center’s website at www.iacenter.org/depleted/du.htm includes an impressive amount of information and links to resources regarding the use of depleted uranium in tank armor and armor-piercing bullets and missiles in the Gulf War, the dangerous consequences of such use, the lack of government recognition of the possibility of depleted uranium as a major factor in Gulf War illnesses, and the international community’s movement (including among some NATO allies) to ban the use of depleted uranium.

From the VA website at www.va.gov/health/environ/faq.htm

What is "Gulf War Syndrome" and what are the causes?

"Gulf War Syndrome" is a non-scientific label that has frequently been used to describe those veterans with unexplained illnesses often characterized by fatigue, joint pain, skin rash, memory loss and/or diarrhea. Five panels of experts agree that this group of veterans is probably not suffering from a single, common ailment, but rather from a variety of illnesses with overlapping symptoms.

A number of potential causes have been postulated and investigated, but to date no single theory appears likely to explain all of these undiagnosed conditions. Among some of the more common theories are: exposure to low levels of chemical agents; an unusual chronic infectious disease; exposure to biologic warfare agents; side effects of vaccines or medications administered to Gulf War participants; or some combination of these factors.

In tens of thousands of protocol medical examinations of Persian Gulf veterans to date, neither VA nor DoD medical authorities have found evidence of infectious diseases beyond the range of illnesses common in the population at large. Research studies now in progress will provide more scientific answers to this question, but no rigorous, reproducible research to date has established that Gulf War veterans' illnesses are caused by an infectious agent.

How many Gulf War veterans are sick, what symptoms do they have and how many have unexplained illnesses?

Of the 697,000 U.S. troops who served during Operation Desert Shield and Desert Storm, more than 100,000 have registered with the Department of Veterans Affairs (VA) or the Department of Defense (DOD), saying they have health concerns. While most of these veterans have been diagnosed with a variety of conditions, more than 15,000, or about 20 percent of those examined, have undiagnosed symptoms, which commonly include fatigue, muscle and joint pains, headaches, memory loss, skin rash, diarrhea and sleep disturbances.

Is it possible that still more veterans are suffering from illnesses but have not registered with the VA or DOD?

Yes. Any Persian Gulf veteran who is concerned about his or her health is encouraged to take advantage of the free, confidential registry program. Those who have left active military service should call the VA at 1-800-PGW-VETS.

Is it possible that battlefield stress that does not result in PTSD can nonetheless contribute to other chronic health problems?

This is a very real possibility that is being actively investigated. Stress can cause psychological as well as physical effects. New research shows that stress can affect the nervous system, immune system, and hormones in the body. Clearly, chronic stress has been associated with a variety of common ailments, such as ulcers, high blood pressure and certain types of heart disease. However, research is needed to determine if stress caused physical illness in Persian Gulf veterans. Stress would not account for all illnesses reported by Persian Gulf veterans.

What are the chemical warfare agents to which some veterans were possibly exposed and what effects can they have, short-term and long-term?

DoD information suggests that a number of U.S. troops may have been exposed to low levels of a class of chemical warfare agents known as nerve agents. These compounds alter nerve transmissions and result in a variety of symptoms, including a runny nose and tearing; changes in vision; increased salivation; difficulty in

breathing; stomach cramps; muscle twitching; and convulsions and death at higher exposure levels. These symptoms develop within minutes of exposure to nerve agents.

Individuals who survive a serious acute poisoning may experience delayed effects on the nervous system and, in some cases, have shown very subtle changes in the brain waves or EEG. However, these long-term effects have not been confirmed to date in individuals exposed to very low levels of nerve agents.

Veteran concerns also include exposure to the rubble and dust from exploded shells made from depleted uranium; the possibility of exposure to the nerve agent sarin or some yet-unconfirmed Iraqi chemical-biological agent; and use of a nerve agent pre-treatment drug, pyridostigmine bromide. Many other risk factors also have been raised. In 1991, VA initially began to develop tracking mechanisms that matured into the Gulf War Registry as a direct consequence of early concerns about the environmental influence of oil well fires and their smoke and particulate.

Who pays for the care of veterans who are sick, and are they eligible for disability income?

Comprehensive medical care is available at no cost to the veteran through the VA for Persian Gulf veterans with medical problems thought to be possibly related to a hazardous exposure during their service in the Gulf War. Care may not be available, however, or may require co-payment by the veteran, if the illness is determined to be clearly unrelated to their Persian Gulf service.

If an illness or injury associated with service in the Persian Gulf results in a persistent disability, the veteran may be eligible for disability compensation from the VA. New legislation also authorizes disability compensation for Persian Gulf veterans with chronic, undiagnosed illnesses resulting in a permanent disability that developed after they left the Persian Gulf. VA published regulations April 29, 1997, to expand eligibility for compensation through December 31, 2001, for Persian Gulf War veterans with undiagnosed illnesses. This replaces a previous two-year limitation on the period in which Gulf War veterans' undiagnosed illnesses may become manifest in order to be presumed related to their service.

What special health programs are available for Gulf War veterans?

A free, complete physical examination with basic lab studies is offered to every Gulf War veteran, whether or not the veteran is ill. A centralized registry of participants, begun in August 1992, is maintained to enable VA to update veterans on research findings or new compensation policies through periodic newsletters. This clinical database could suggest areas to be explored in future scientific research. The 67,000 Gulf War veterans who have taken advantage of the physical examination program become part of a larger Gulf War Registry. As defined by PL 102-585, this includes about 242,000 Gulf War veterans (generally including those counted in the special examination program) who have been seen for routine VA hospital or clinic care, or who have filed compensation claims – or whose survivor registers a claim. If the veteran's illness defies diagnosis, the veteran may be referred to one of four Gulf War Referral Centers. Created in 1992, the first centers were located at VA medical centers in Washington, DC, Houston, and Los Angeles, with an additional center designated at Birmingham, AL, in June 1995.

VA has designated a physician at every VA medical center to coordinate the special examination program and to receive updated educational materials and information as experience is gained nationally. Where an illness possibly related to military service in the Southwest Asia theater of operations during the Gulf War is detected during the examination, follow-up care is provided on a higher-eligibility basis than most non-service-connected care. As with the health examination registry, VA requested and received special statutory authority to bypass eligibility rules governing access to the VA health system.

VA offers a toll-free information line at 1-800-PGW-VETS (800-749-8387) where operators are trained to help veterans with general questions about medical care and other benefits. It also provides recorded messages that enable callers to obtain information 24 hours a day.

What government agencies or official panels have investigated Gulf War sickness, what have they found, and why are their findings not yet conclusive?

Several prestigious government and non-government scientific panels have reviewed Gulf War illnesses and possible factors that may have led to the occurrence of a variety of illnesses, but have concluded that the illnesses are likely the result of many different causes with overlapping symptoms. These panels include three Institute of Medicine committees, the Defense Science Board, a National Institutes of Health workshop, the VA Persian Gulf Expert Scientific Committee, and the Presidential Advisory Committee on Gulf War Veterans' Illnesses.

A number of recommendations from the panels have proved extremely helpful in planning research to more fully understand both the nature and causes of these illnesses. None of the findings to date fully explains the cause or causes of Persian Gulf illnesses.

Are there studies under way that can answer, definitively, whether or not there is a Gulf War Syndrome and, if so, what are these studies and how long will they take?

A large number of studies are now in progress that will contribute to our understanding of Gulf War illnesses, including epidemiological studies that will compare the types and frequency of illnesses in Gulf War veterans compared to veterans who did not serve in the Gulf War. This work will provide valuable information about what types of illness may have resulted from military service in the Gulf War.

Preliminary results from several of these studies should be available within the next year. In addition, more than 90 research studies are under way that will examine possible health consequences of exposure to a variety of factors present in the Persian Gulf, such as depleted uranium, pesticides, pyridostigmine bromide and chemical warfare agents.

For more information on VA research being conducted on Gulf War veterans' health, go to www.va.gov/pressrel/pgrsch98.htm

For other information on Gulf War illnesses, go to www.va.gov/health/environ/persgulf.htm which also includes issues of the "Gulf War Review."

What other health conditions may be related to a veteran's military experience?

Prisoners of War (POWs)

Former prisoners of war who were incarcerated for at least 30 days are presumed to be eligible for disability compensation if they become at least 10% disabled from diseases associated with POWs. These presumptive diseases are avitaminosis, beriberi heart disease and ischemic heart disease, chronic dysentery, helminthiasis, malnutrition including optic atrophy, pellagra and other nutritional deficiencies, psychosis, anxiety states and dysthymic disorder or depressive neurosis, post-traumatic osteoarthritis, irritable bowel syndrome, peptic ulcer disease, peripheral neuropathy and residuals of cold injury to include arthritis, neuropathy and skin cancer at the site of the cold injury. (See the website at www.va.gov/oph/cold/ for in-depth clinical information on cold injuries.)

Veterans Exposed to Radiation

Health care services are available for medical conditions the VA recognizes as possibly related to a veteran's exposure to ionizing radiation from the following sources:

- detonation of a nuclear device in connection with nuclear tests (between 1945 and 1962);
- the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning Sept. 11, 1945, and ending July 1, 1946;
- internment as a prisoner of war in Japan during World War II which the VA determines resulted in exposure to ionizing radiation; or
- treatment of any cancer of the head or neck which the VA finds may be associated with the veteran's receipt of NP radium irradiation treatments while in the active military.

Veterans exposed to ionizing radiation while on active duty may be eligible for disability compensation if they have disabilities related to that exposure. To determine service-connection, factors considered include amount of radiation exposure, duration of exposure and elapsed time between exposure and onset of the disease. Conditions presumed to be service-connected are all forms of leukemia except for chronic lymphocytic leukemia; cancer of the thyroid, breast, pharynx, esophagus, stomach, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary tract, bronchiolo-alveolar carcinoma, multiple myeloma, primary liver cancer and lymphomas other than Hodgkin's disease.^{xxviii}

Hepatitis C

In 1991, the VA began tracking the number of veterans seen in VA Medical Centers (VAMCs) who were positive for antibody to the hepatitis C virus (HCV) and discovered 6,600 of them. In 1994, there were 18,800 and by 1996 there were 21,400.^{xxix} A recent Veterans Health Administration (VHA) study shows that veterans within the VHA healthcare system have a 10% prevalence for the hepatitis C virus, which is four to five times greater than the infection rate among the general population. In this study, Vietnam veterans accounted for more than 60% of all positive test results.^{xxx}

Vietnam veterans, particularly those who were wounded or those in the medical care field, are at increased risk if they received blood transfusions or products prior to 1990 or if they were exposed to blood or blood products. Other risk factors for contracting HCV include IV drug use, tattooing, and multiple sex partners. People infected with the hepatitis C virus may not experience symptoms for many years, or until serious liver damage has occurred. Left unchecked, hepatitis C can lead to cirrhosis (scarring of liver) and liver cancer. It is the leading cause of liver transplantation in the U.S. Each year, up to 10,000 Americans die due to hepatitis C, and experts predict that the annual number of HCV-related deaths may triple in the next two decades.^{xxxi} Additional information about HCV and testing for it, as well as anticipated treatment availability for veterans, are available at the nearest VAMC.

3 Eligibility Criteria

Eligibility for VA benefits and services

Unless otherwise indicated, the following information is from the VA website at www.va.gov

What makes a veteran eligible for VA benefits and services?

Eligibility for most VA benefits is based upon *discharge from active military service under other than dishonorable conditions*. Active service means full-time service as a member of the Army, Navy, Air Force, Marines, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration or the National Oceanic and Atmospheric Administration.

Although certain benefits or services require additional eligibility criteria (such as service during wartime, or a service-connected disability), the general guidelines are as follows:

- A veteran with an honorable or general discharge qualifies for most VA benefits.
- A veteran with a dishonorable or bad conduct discharge issued by general courts-martial is barred from receiving VA benefits.
- Veterans in prison and parolees may be eligible for certain VA benefits. VA regional offices can clarify eligibility of prisoners and parolees.

Some benefits (e.g., disability pension) specifically require that the veteran have served during a period that includes war time. Under the law, the VA recognizes the following as periods of war time (periods before WWII not included here):

- **World War II** – December 7, 1941, through December 31, 1946
- **Korean Conflict** – June 27, 1950, through January 31, 1955
- **Vietnam Era** – August 5, 1964 (February 28, 1961, for veterans who served “in country” before August 5, 1964) through May 7, 1975
- **Gulf War** – August 2, 1990, through a date to be set by law or Presidential Proclamation

Other benefits and services require that the veteran have a *service-connected disability*. An adjudicated service-connected disability is one that the VA has determined was incurred or aggravated in the line of active duty. Disabilities are rated from zero, or noncompensable, to 100% disabling, in increments of 10%. If there are two or more disabilities, the individual percentages of each are used to determine a combined disability evaluation.

Table 5 provides a framework for understanding the complexities of service-connected and disability ratings. Basic information on eligibility for benefits is also available from the VA’s Help Line at 1-800-827-1000.

TABLE 5
Understanding Eligibility Based on Service-Connection and Disability*

	DISABLING CONDITION	NON-DISABLING CONDITION
SERVICE-CONNECTED	<p>“Compensable 10% - 100% service-connected disability”</p> <p><i>Veteran has at least one condition that IS service-connected AND disabling (i.e., rated at least 10% disabling)</i></p> <p>ELIGIBLE for:</p> <ul style="list-style-type: none"> • VA disability compensation • VA pension (if other criteria met) • Priority 1-3 enrollment in VA health care depending on % rating of disability • Outpatient dental treatment (if dental condition is service-connected OR if other service-connected disability is 100%) • Nursing home care (if care is for the service-connected condition OR if other service-connected disability is at least 70%) 	<p>“Noncompensable 0% service-connected disability”</p> <p><i>Veteran has at least one condition that IS service-connected but NOTHING that is rated as disabling (i.e., rating is less than 10% disabling)</i></p> <p>ELIGIBLE for:</p> <ul style="list-style-type: none"> • Priority Group 5 health care enrollment, if low-income • Outpatient dental treatment (if dental condition connected to combat or service injury, even if noncompensable) • Nursing home care (if care is for the service-connected condition) <p>NOT ELIGIBLE for:</p> <ul style="list-style-type: none"> • VA disability compensation • VA pension
NOT SERVICE-CONNECTED	<p>“Compensable nonservice-connected disability”</p> <p><i>Veteran has at least one condition that is disabling, but NO condition that is service-connected</i></p> <p>ELIGIBLE for:</p> <ul style="list-style-type: none"> • VA pension (if other criteria met) • Priority 5 enrollment in VA health care (if low-income) • Outpatient dental treatment (if dental condition is aggravating a medical condition) <p>NOT ELIGIBLE for:</p> <ul style="list-style-type: none"> • VA disability compensation 	<p>“Noncompensable nonservice-connected”</p> <p><i>Veteran has NO service-connected condition and NO disabling condition</i></p> <p>ELIGIBLE for:</p> <ul style="list-style-type: none"> • Priority 5 enrollment in VA health care (if low-income) • Outpatient dental treatment (if dental condition is aggravating a medical condition) <p>NOT ELIGIBLE for:</p> <ul style="list-style-type: none"> • VA disability compensation • VA pension

* This chart was prepared by the author for purposes of clarification based on available information from the VA. It does not represent an official version of VA policy or practice.

What is a VSO and how can they help homeless veterans?

Veterans Service Organizations (VSOs) are non-profit community-based organizations devoted to serving the interests of veterans, usually with a membership base consisting of veterans. Certain VSOs have a veteran's advocate Service Officer who is authorized to legally represent and support veterans on issues related to their status, including application for benefits, appeals, discharge upgrades, etc. All veterans are encouraged to make use of these services when dealing with any of the issues presented in this section. The larger VSOs have national offices with posts or chapters in communities across the country. Some of these are listed in Appendix C with information for contacting a Service Officer. For a complete list of all VSOs go to www.va.gov/vso/default.asp.

What documents and information are required to apply for VA benefits?

Those seeking a VA benefit for the first time must submit a copy of their service discharge, DD-214, which documents service dates and type of discharge, or give their full name, military service number, branch of service and dates of service. The claim number assigned by VA to the initial claim should be referred to in subsequent correspondence. VSOs are very helpful during this process.

How can lost military records be replaced?

VSO Service Officers are available to help veterans with getting military records replaced (see VSOs above). The VA offers the following information regarding this process:^{xxxii}

If discharge or separation papers are lost, duplicate copies may be obtained by contacting the National Personnel Records Center, Military Personnel Records, 9700 Page Blvd., St. Louis, MO 63132-5100. Specify that a duplicate separation document or discharge is needed. The veteran's full name should be printed or typed so that it can be read clearly, but the request must also contain the signature of the veteran or the signature of the next of kin, if the veteran is deceased. Include branch of service, service number of Social Security number and exact or approximate dates and years of service. Use Standard Form 180, "Request Pertaining to Military Records," available from VA offices or at the VA forms web site <http://www.va.gov/forms>. It is not necessary to request a duplicate copy of a veteran's discharge or separation papers solely for the purpose of filing a claim for VA benefits. If complete information about the veteran's service is furnished on the application, the VA will obtain verification of service from the national Personnel Records Center or the service department concerned. In a medical emergency, information from a veteran's records may be obtained by phoning the appropriate service:

Army – (314) 538-4261

Air Force – (314) 538-4243

Navy, Marine Corps or Coast Guard – (314) 538-4141

How many homeless veterans are not eligible for VA services?

About 11% of homeless veterans left the military with a less than honorable discharge, also known as "bad paper" which makes them ineligible for any VA services or benefits.^{xxxiii}

Is there a way to change a veteran's discharge status?

VSO Service Officers are available to help veterans with upgrading their discharge status (see VSOs above). The VA offers the following information regarding this process:^{xxxiv}

Each of the military services maintains a discharge review board with authority to change, correct, or modify discharges or dismissals that are not issued by a sentence of a general court martial. The board has no authority to address medical discharges. The veteran or, if the veteran is deceased or incompetent, the surviving spouse, next of kin or legal representative may apply for a review of discharge by writing to the military department concerned, using Department of Defense Form 293. This form may be obtained at a VA

office. If more than 15 years have passed since discharge, DD Form 149 should be used. Service discharge review boards conduct hearings in Washington, DC. Traveling review boards also visit selected cities to hear cases. In addition, the Army sends teams to locations to videotape the testimony of applicants for later review by a board in Washington, DC. Discharges awarded as a result of unauthorized absence in excess of 180 days make persons ineligible for VA benefits regardless of action taken by discharge review boards, unless the VA determines there were compelling circumstances for the absences. Boards for the correction of military records also may consider such cases.

Veterans with disabilities incurred or aggravated during active military service may qualify for medical or related benefits regardless of separation and characterization of service. Veterans separated administratively under other than honorable conditions may request that their discharge be reviewed for possible recharacterization, provided they file their appeal within 15 years of the date of separation. Questions regarding the review of a discharge may be addressed to the appropriate discharge review board at the following addresses:

Army Army Discharge Review Board, Attention: SFMR-RBB
1941 Jefferson Davis Hwy., Room 200A
Arlington, VA 22202-4505.

Navy/USMC Navy Discharge Review Board
801 N. Randolph St., Suite 905
Arlington, VA 22203

Air Force Air Force Military Personnel Center
Attention: DP-MDOA1
Randolph AFB, TX 78150-6001

Coast Guard Coast Guard
Attention: GPE1
Washington, DC 20593

How can military records be corrected?

Contact a VSO Service Officer for assistance in the following VA-recommended process:^{xxv}

The secretary of a military department, acting through a board for correction of military records, has authority to correct any military record when necessary to correct an error or remove an injustice.

Applications for correction of a military record, including review of discharges issued by courts martial, may be considered by a correction board. A request for correction generally must be filed by the veteran survivor or legal representative within three years after discovery of the alleged error or injustice. The board may excuse failure to file within the prescribed time, however, if it finds it would be in the interest of justice to do so. It is the responsibility of the applicant to show why the filing of the application was delayed and why it would be in the interest of justice for the board to consider the application despite the delay. To justify any correction, it is necessary to show to the satisfaction of the board that the alleged entry or omission in the records was in error or unjust. Applications should include all available evidence, such as signed statements of witnesses or a brief of arguments supporting the requested correction. Application is made with DD Form 149, available at any VA office or at the VA forms web site <http://www.va.gov/forms>.

The following instructions are directed to veterans from the Compensation and Pension Service staff of the Veterans Benefits Administration, Department of Veterans Affairs Central Office, Washington, DC.^{xxxvi} (VSO Service Officers should be used for assistance in this appeal process. See VSOs above.)

If a claim for a service-connected disability is denied, how can it be appealed?

If the VA Regional Office says your disability is not service-connected or if the percentage of disability is lower than what you think is fair, you have the right to appeal to the Board of Veterans' Appeals. The first step in appealing is to send the VA Regional Office a "Notice of Disagreement." This Notice of Disagreement is a written statement saying that you "disagree" with the denial. Be sure your Notice includes the date of the VA's denial letter and be sure to list the benefits you are still seeking.

The Notice of Disagreement must be mailed to the VA Regional Office within one year of the VA Regional Office's denial of your claim or you cannot appeal.

In response to the Notice of Disagreement, you will get a "Statement of the Case" from the VA Regional Office. This will repeat the reasons stated in the VA's denial letter why your claim was denied and will include the relevant VA regulations. Once you get the Statement of the Case, if you still wish to pursue your appeal, you should file a VA Form 9, "Appeal to Board Veterans' Appeals," which is sent with the Statement of the Case. You have 60 days from the date on the Statement of the Case, or one year from the date the VA first denied your claim, to file the VA Form 9. Whichever date is later is your deadline.

At any point, you can request a hearing at the VA Regional Office.

Can I appeal beyond the VA Regional Office?

The Board of Veterans' Appeals (also known as "BVA") is a part of the VA, located in Washington, DC. Members of the BVA review benefit claims decisions made by VA Regional Offices and issue a new decision. You may have a hearing before the BVA in Washington, DC, or at your VA Regional Office.

Anyone appealing to the BVA should read the "Understanding the Appeal Process" pamphlet. It explains the steps involved in filing an appeal and to serve as a reference for the terms and abbreviations used in the appeal process. The board mails a copy of the pamphlet to anyone who appeals their case. It is also available on the Internet at <http://www.va.gov/vbs/bva/index.htm>.

Can I appeal to a Court?

If the BVA does not grant all the benefits you are seeking, you have four choices:

- 1. Decide not to pursue your claim.***
- 2. Appeal to the U.S. Court of Appeals for Veterans Claims.***

You may appeal to the Court only if BVA has denied some or all of your benefits. You may not appeal a BVA decision to remand your claim back to the VA Regional Office. You must file your appeal by mail or fax. Send your name, address, phone number, and the date of the BVA decision to:

Clerk of the Court
U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue NW
Washington, DC 20004
Fax number: (202) 501-5848

To get a list of veterans' representatives who practice at the Court, and for more information on the Court, see the Court's web site at <http://www.vetapp.gov/AboutCourt/HowToAppeal.asp>. This list is also available by calling the Court at 1-800-869-8654.

3. *Ask the BVA to reconsider its decision.*

The BVA will reconsider its denial decision, if it finds an "obvious error of fact or law" in that decision. Such a request should be sent to the BVA.

4. *Reopen your case at the VA Regional Office with new and material evidence.*

If you can get additional evidence about your case which is both new and material, you can reopen your claim at the VA Regional Office and get a new decision.

What additional resources are available to help in the claims process?

The Vietnam Veterans of America (VVA) recommends the following publications:

- ***Veterans Benefits*** — 410 page paperback written for the veteran; sections on VA benefits, claims procedures, advocacy tips; published by HarperCollins; to order from VVA Veterans Collectibles, call 1-800-626-8387.
- ***Veterans Benefits Manual and Supplement*** — written for VSO Services Representatives; details on filing, presenting claims for full range of VA benefits; offered by National Veterans Legal Services Program; to order, call 202-265-8305.
- ***Title 38, Code of Federal Regulations*** — the official set of VA regulations; available from the Government Printing Office; to order, call 202-512-1800.
- ***Veterans Appeals Reporter*** — contains decisions of Court of Veterans Appeals; published by West Publishing Co.; available at nearest VARO.

See also Appendix I for more information on legal services.

4 VA Health Programs

VA health services for all eligible veterans

Unless otherwise noted, the information presented in this chapter is taken from the VA website at <http://www.va.gov/vbs/health/>

What VA health care services are available to homeless veterans?

Health services are offered to eligible veterans through the Veterans Health Administration (VHA). The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262 brought many changes to the VA health care system. One change was the establishment of a ***Uniform Benefits Package*** that is generally available to all *enrolled* veterans (see below for information on enrollment).

Covered services include:

- Drugs, biologicals, and medical devices approved by the FDA
- Elective sterilization (tubal ligation or vasectomy)
- Emergency care in VA facilities
- Home health care
- Hospice care
- Hospital and outpatient care
- Maternity benefits
- Medical and surgical care
- Mental health care
- Palliative care
- Preventive care and services
- Prosthetics and orthotics
- Rehabilitation care and services
- Respite care
- Substance abuse services

Services that are ***not*** covered include:

- Abortions and abortion counseling
- Drugs, biologicals and medical devices not approved by the FDA
- Gender alterations
- Membership in health clubs or spas
- Private duty nursing

Services that are covered under *special authorities* (i.e., requiring specific eligibility) include:

- Adult day health care
- Dental care
- Domiciliary care
- Emergency care in non-VA facilities
- Homeless programs
- Non-VA care
- Nursing home care
- Readjustment counseling service (at Vet Centers)
- Sensori-neural aids (i.e., eyeglasses, contact lenses, hearing aids)
- Sexual trauma counseling

Women veterans are eligible for the same VA benefits as male veterans. Additional services and benefits for women veterans are gender-specific, and include breast and pelvic examinations and other general reproductive health care services. Preventive health care provided includes counseling, contraceptive services, menopause management, Pap smears and mammography. Referrals are made for services that the VA is unable to provide. To ensure privacy for women veterans, Women Veterans' Coordinators are available at all VA facilities to assist women veterans seeking treatment and benefits.

How does a veteran enroll for these health services?

The Veterans' Health Care Eligibility Reform Act of 1996 mandated the VA to establish and implement a national enrollment system to manage the delivery of health care services, which became effective October 1, 1998. The enrollment application, VA Form 10-10EZ, is available at all VA medical centers/clinics, benefits offices, and at www.va.gov/health/elig, and may be mailed, delivered or submitted on-line. All eligible veterans are encouraged to enroll – which may be done at any time during the year – but the following categories of veterans are not required to enroll in order to receive services:

- Veterans who need treatment for a VA-rated service-connected disability
- Veterans with a VA-rated service-connected disability of 50% or more (regardless of whether needed treatment is for a service-connected condition)
- Veterans who were released from active duty within the previous 12 months for a disability incurred or aggravated in the line of duty

Veterans are *not* required to have a service-connected disability in order to receive health care services, nor are they only offered treatment for conditions that are service-connected. However, veterans in those situations are placed in a higher priority group for enrollment, as shown in Table 5.

Are copayments required for VA health care services?

As seen in Table 5, no copayments for care or medications are required when care is for a service-connected disability, or if the veteran has at least a 50% service-connected disability, or if the veteran meets the low-income requirement. Most nonservice-connected veterans and noncompensable 0% service-connected veterans are required to complete an annual means test or to agree to pay VA the applicable copayment.

What is a means test?

Certain nonservice-connected veterans are required to fill out the financial worksheet, which is referred to as the "Means Test." A means test is a gathering of financial information by which the VA determines veterans' priority group for enrollment, and whether or not they are required to make copayments for the services received. The means test is based on prior year income and net worth. However, veterans can apply for an exemption from paying those copayments to avoid a hardship if projections of income for the current year are that it will be substantially below the applicable income threshold.

TABLE 6 – Enrollment Priorities for VA Health Care

PRIORITY GROUP	ELIGIBILITY CRITERIA	Treatment for SERVICE-CONNECTED condition	Treatment for NONSERVICE-CONNECTED condition
PRIORITY GROUP 1	Veterans with service-connected disabilities rated 50% or more disabling.	Covered by VA – no copayment for care or medications.	No prescription copayment. Treatment for nonservice-connected conditions will be billed by VA to health insurance company, if veteran is covered.
PRIORITY GROUP 2	Veterans with service-connected disabilities rated 30% to 40% disabling.	Covered by VA – no copayment for care or medications.	Pay prescription copayment of \$2 for each 30-day supply (or less) for nonservice-connected condition. Treatment for nonservice-connected conditions will be billed by VA to health insurance company, if veteran has coverage.
PRIORITY GROUP 3	<ul style="list-style-type: none"> • Veterans with service-connected disabilities rated 10% to 20% disabling • Veterans who are former POWs. • Veterans who are awarded the Purple Heart. • Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty. • Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation.” 	Covered by VA – no copayment for care or medications.	
PRIORITY GROUP 4	<ul style="list-style-type: none"> • Veterans who are receiving aid and attendance or housebound benefits. • Veterans who have been determined by VA to be catastrophically disabled. 	Covered by VA – no copayment for care or medications.	
PRIORITY GROUP 5	Nonservice-connected veterans and service-connected veterans rated 0% disabled whose annual income and net worth are below the established dollar threshold (changes every year).	Covered by VA – no copayment for care or medications.	No prescription copayment. Treatment for nonservice-connected conditions will be billed by VA to health insurance company, if veteran is covered.
PRIORITY GROUP 6	<p>All other eligible veterans who are not required to make copayments for their care, including:</p> <ul style="list-style-type: none"> • WWI and Mexican Border War veterans • Compensable 0% service-connected veterans • *Veterans receiving care solely for disabilities resulting from exposure to toxic substances, radiation or for disorders associated with service in the Gulf War; or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.* 	Covered by VA – no copayment for care or medications.	<p>Pay a prescription copayment of \$2 for medication for nonservice-connected conditions, unless they meet the low-income exemption.</p> <p>Treatment for nonservice-connected conditions will be billed by VA to health insurance company, if veteran is covered.</p> <p>*Must pay applicable copayments for care when condition is not related to exposure or experience.</p>
PRIORITY GROUP 7	Nonservice-connected veterans and noncompensable 0% service-connected veterans whose needed care cannot be provided by enrolling in any of the groups above and who agree to pay specified copayment.	Not applicable	Copayments required for inpatient care, outpatient care, nursing homes, and medications. Copayment may be covered by health insurance, if veteran is covered.

What if the veteran has other health insurance coverage or Medicaid?

Whether or not a veteran has other health insurance, including Medicaid or Medicare, does not affect eligibility for VA health care benefits. If a veteran with private insurance receives care for a nonservice-connected condition, the law requires the VA to bill the private health insurance company for that care. The VA's medical care budget is supplemented by the amount they are able to collect from private health insurance carriers. However, veterans are *not* responsible for any unpaid balance that the insurance carrier does not pay *except* for VA copayments when applicable. The VA will *not* bill the health insurance carrier when the care is provided for any VA-adjudicated service-connected disability.

What if the veteran is unable to make the copayment?

There are two options for veterans who cannot afford to make a required copayment:

1. Request a waiver for paying the current debt. This must be submitted with sufficient proof that the veteran is financially unable to make the payment, and the process could take several months. Contact the Medical Care Cost Recovery Coordinator at the VA health care facility where care is received.
2. Request a hardship determination to avoid future debts by being placed in a different priority group. This requires submission of specific financial information about current year income to show a change from the previous year. Circumstances that might warrant hardship consideration would be the loss of employment, business bankruptcy or out-of-pocket medical expenses.

Where can veterans get these health care services?

In the mid-1990s, the VA health care system was reorganized into 22 Veterans Integrated Service Networks (VISNs), based on geographic referral patterns to maximize access to care and improve service delivery efficiencies. (See www.va.gov/stations97/guide/map.asp for a map of all VISNs.)

VISNs offer a full continuum of care to patients within their boundaries through direct delivery or contractual agreements with other networks or providers. A typical network consists of six to ten hospitals that provide acute inpatient medical and surgical, psychiatric, and substance abuse services, along with subacute and rehabilitation services. Each network also manages 20 to 30 freestanding outpatient clinics, nine to ten readjustment counseling centers, six to eight home-based primary care programs, five to seven nursing homes, one or more residential housing facilities (domiciliaries), and contracts with 140-150 community nursing homes and several state veterans' homes.^{xxxvii}

Following is a list of the services and facilities available through the VISNs. Although veterans are asked to designate their "preferred facility" for primary care, benefits are portable and they only need notify the VA if they need to change to another location.

➤ *VA Medical Centers*

Based on their extremely low income levels, eligible homeless veterans should qualify for free medical services at VA medical centers throughout the United States. A listing of all VA medical facilities is available at <http://www.va.gov/pubaff/fedben/00fedben.pdf>. (The directory starts on page 77 of the PDF document.) Appendix J also gives contact information for each VA medical center.

➤ *Inpatient and Outpatient Psychiatric and Substance Abuse Programs*

Any veterans eligible for VA medical care may apply for psychiatric or substance abuse treatment. Capacity for inpatient treatment is approximately 8,400 beds. Outpatient services are offered in mental health clinics, day treatment centers, hospital day programs, and alcohol- and drug-dependence treatment programs. The VA also supports contract care in community-based facilities for veterans with substance abuse disorders. (See Chapter 6 for information on psychiatric and substance abuse programs targeted to homeless veterans.)

➤ ***Outpatient Dental Treatment***

Outpatient dental treatment provided by the VA includes examinations and the full spectrum of diagnostic, surgical, restorative and preventive procedures. Some veterans receiving dental care may be billed the applicable copayment if their income exceeds the maximum threshold. The following veterans may receive care:

1. veterans having service-connected and compensable dental disabilities or conditions;
2. former prisoners of war incarcerated 90 days or more;
3. veterans with service-connected noncompensable dental conditions as a result of combat wounds or service injuries;
4. veterans with nonservice-connected dental conditions determined by the VA to be aggravating a medical problem;
5. veterans having service-connected conditions rated at 100%; and
6. veterans participating in a vocational rehabilitation program.

Veterans may receive one-time dental treatment for service-connected and noncompensable dental disabilities or conditions, if the following conditions are met: the dental condition can be shown to have existed at time of discharge; the veteran served on active military duty for at least 180 days (or 90 days during the Gulf War Era); the veteran applied to the VA for dental care within 90 days of discharge or release from active duty, and the certificate of discharge does not include certification that all appropriate dental treatment had been rendered prior to discharge.

➤ ***Nursing Home Care***

Nursing care in VA or private nursing homes may be provided for veterans who are not acutely ill and not in need of hospital care. VA will provide needed nursing-home care to:

- any veteran in need of such care for a service-connected disability; and
- any veteran with a service-connected disability rated at 70% or more who needs care for a condition which is not service-connected.

In addition, if space and resources are available, the VA may also provide VA nursing-home care to other veterans. Veterans who have a service-connected disability are given first priority for nursing-home care. Applicants who may be provided nursing-home care without an income eligibility assessment include veterans with a compensable, service-connected disability, veterans who were exposed to herbicides while serving in Vietnam, veterans exposed to ionizing radiation during atmospheric testing or in the occupation of Hiroshima and Nagasaki, veterans with a condition related to an environmental exposure in the Gulf War, veterans who are former prisoners of war, veterans on VA pension, veterans of the Mexican Border period or World War I and veterans who are eligible for Medicaid.

Nonservice-connected veterans and 0% noncompensable service-connected veterans requiring nursing-home care for any nonservice-connected disability must complete the financial section on VA Form 10-10EZ, to determine whether they will be billed for nursing-home care. Income assessment procedures are the same as for hospital care.

Veterans who are receiving health care from the VA may be transferred to a private nursing home at VA expense. VA-authorized care normally may not be provided in excess of six months, except for veterans who need nursing-home care for a service-connected disability or veterans who were hospitalized primarily for treatment of a service-connected disability.

Portions of the nursing-home care program may vary from what is indicated here as a result of recent legislation. Call your nearest benefits or health care facility to obtain the latest information.

➤ ***Readjustment Counseling Services – Vet Centers***

VA-operated Vet Centers have homeless coordinators that provide outreach, psychological counseling, supportive social services and referrals to other VA and community programs. Some 140,000 veterans make more than 800,000 visits to VA's 206 Vet Centers each year. As many as 10% of Vet Center clients are homeless during winter months.

Readjustment counseling is provided at Vet Centers to help veterans resolve psychological war trauma and to help them achieve a successful post-war adjustment to civilian life. Assistance includes group, individual and family counseling. Eligible for counseling are veterans who served on active duty in a combat theater during World War II, the Korean Conflict, the Vietnam Era, the Gulf War, or the campaigns in Lebanon, Grenada, Panama or Somalia. Veterans who served in the active military during the Vietnam Era are also eligible, provided they have requested services at a Vet Center before January 12, 2004.

Psychological readjustment problems include post-traumatic stress disorder (PTSD). This refers to such symptoms as nightmares, intrusive recollections or memories, anxiety or sudden reactions following exposure to traumatic wartime conditions. Readjustment difficulties may affect functioning in school, family or work. Counseling also is provided for trauma due to sexual assault or harassment while on active duty. In areas distant from Vet Centers or VA medical facilities, veterans may obtain readjustment counseling from private-sector professionals who are on contract with the VA. To obtain additional information about available services, contact the nearest Vet Center. A list of Vet Centers is available in Appendix B or at www.va.gov/station/VetCenter/Telephone.htm.

➤ ***Vocational Rehabilitation and Counseling***

Vocational Rehabilitation and Counseling is an employment-oriented program that assists veterans with service-connected disabilities by offering them services and assistance to help them prepare for, find and keep suitable employment. Suitable employment is work that is within the veterans' physical and emotional capabilities and matches their patterns of skills, abilities and interests. For veterans whose disabilities make employment unlikely, VA helps them attain as much daily living independence as possible.

A veteran must have a VA established service-connected disability of at least 10% with a serious employment handicap or 20% with an employment handicap and be discharged or released from military service under other than dishonorable conditions.

Depending on an individual's needs, services provided by the VA may include:

1. an evaluation of the individual's abilities, skills and interests
2. assistance finding and maintaining suitable employment
3. vocational counseling and planning
4. training, such as on-the-job and work experience programs
5. training, such as certificate, two, or four-year college or technical programs
6. supportive rehabilitation services and additional counseling

VA pays the cost of these services and pays a living allowance to veterans who participate in a training program. Generally, veterans must complete a vocational rehabilitation program within 12 years of separation from military service or within 12 years of compensable service-connected disability award notification by the VA.

To get more specific information about what programs the VA offers in your state go to:

<http://www.va.gov/opa/fact/statesum/index.htm>

5 VA Benefits

VA benefits for all eligible veterans

What is the difference between disability compensation and disability pension?

The primary differences have to do with whether or not the disability is service-connected (required for compensation) or if the veteran served during war-time (required for pension). Other differences are described below. See also the chart describing eligibility based on service-connection and disability in Chapter 3.

➤ **Disability Compensation**

Disability Compensation is a monthly monetary benefit paid to veterans who are disabled by injury or disease incurred or aggravated during active military service (wartime or peacetime), including disabilities or injuries resulting from sexual trauma, and who were discharged or separated under other than dishonorable conditions. The amount of the monthly compensation payment varies with the degree of disability and the number of dependents. The benefits are not subject to federal or state income tax.

Disabilities are rated from zero, or noncompensable, to 100% disabling, in increments of 10%. If there are two or more disabilities, the individual percentages of each are used to determine a combined disability evaluation. Generally, Disability Compensation is not payable for disabilities evaluated at less than 10%. (These are often noted as noncompensable 0% service-connected disabilities.)

**TABLE 7 –
2001 Disability Compensation
(for veteran without dependents)**

www.vba.va.gov/bln/21/Rates/comp01.htm

Disability	Monthly Rate
10 percent	\$ 101
20 percent	194
30 percent	298
40 percent	427
50 percent	609
60 percent	769
70 percent	969
80 percent	1125
90 percent	1266
100 percent	2107

Depending upon the disability rating of the veteran, allowances for a spouse range from \$35 to \$117; and for each additional child, \$18 to \$61. See the web site at www.vba.va.gov/bln/21/Rates/comp01.htm for complete information on rates with and without dependents (children, spouse and/or parents).

Application for Disability Compensation requires VA Form 21-526, Veterans Application for Compensation or Pension. If available, copies should be attached of dependency records (marriage and children's birth certificates) and current medical evidence (doctor and hospital reports). For more information and assistance in applying, contact a Service Officer at a local VSO (see Appendix C) or call the VA toll-free at 1-800-827-1000.

The Social Security Administration (SSA) also offers both disability insurance benefits (SSDI) and supplemental security income benefits (SSI). Veterans can receive both SSDI benefits and VA disability compensation. However, there is an offset of the VA pension or disability compensation if SSI benefits are received. Unlike VA compensation benefits that are measured in degrees of disability, SSA benefits require a total disability that will last at least one year. If a veteran cannot work because of a disability, contact the nearest district office of SSA at 1-800-772-1213. SSA benefits information is available on the Internet at www.ssa.gov. Other sources of information on establishing eligibility for social security benefits can be found in "Determining Disability," a document for health care providers working with homeless people (available at www.nhchc.org/disability.html) or "An Advocate's In-Depth Guide to Social Security and SSI Disability Benefits and Procedures" by Peter H.D. McKee, (January 25, 2000) which is especially helpful when working with clients who are mentally ill. This is available from:

Theiler Douglas Drachler & McKee, LLP
1904 Third Ave., Ste 1030
Seattle, Washington 98104
Phone: 206/623-0900
Fax: 206/623-1432
E-mail: TDDM@aol.com

➤ ***Disability Pension***

Disability Pension is a benefit paid to wartime veterans with limited income who are no longer able to work. Payments are made to qualified veterans to bring their total income, including other retirement or Social Security income, to a level set by Congress (see Table 7). Countable income may be reduced by unreimbursed medical expenses.

Veterans are eligible for VA Disability Pension Benefits if they:

1. were discharged from service under other than dishonorable conditions AND
2. are permanently and totally disabled for reasons other than the veteran's own willful misconduct (does *not* have to be service-connected) AND
3. meet certain income guidelines (see Appendix G) AND
4. served 90 days or more of active duty with at least 1 day during a period of war time.*

* 38 CFR 3.12a requires that anyone who enlists after 9/7/80 generally has to serve at least 24 months or the full period for which a person was called or ordered to active duty in order to receive any benefits based on that period of service. With the advent of the Gulf War on 8/2/90 (and still not ended by Congress as of January 2001), veterans can now serve after 9/7/80 during a period of war time. When they do, they generally now must serve 24 months to be eligible for pension or any other benefit.)

Application for Disability Pension benefits requires VA Form 21-526, Veteran's Application for Compensation or Pension. If available, copies should be attached of dependency records (marriage and children's birth certificates) and current medical evidence (doctor and hospital reports). For more information and assistance in applying, contact a Service Officer at a local VSO (see Appendix D) or call the VA toll-free at 1-800-827-1000.

TABLE 8 – 2001 Improved Disability Pension Rates
www.vba.va.gov/bln/21/Rates/pen01.htm

Status	Maximum Annual Rate
Veteran without spouse or child	\$9,304
With one dependent	12,186
Veteran permanently housebound	11,372
With one dependent	14,253
Veteran needing regular aid and attendance	15,524
With one dependent	18,405
Two veterans married to each other	12,186
Veterans of World War I and Mexican Border Period, addition to the applicable annual rate	2,109
Increase for each additional dependent child	1,586

What other VA benefits are available to eligible veterans, including those who are homeless?

The focus here has been on services related to health and benefits related to disabilities. Information on additional benefits related to education, job training, home loans guaranties, life insurance, burial benefits, and survivors' benefits can be found in the pamphlet "Federal Benefits for Veterans and Dependents" available from a VA office or at www.va.gov/pubaff/fedben/00fedben.pdf.

6 VA Homeless Programs

VA programs designed specifically for homeless veterans

What resources does the VA provide specifically for homeless veterans?

Since 1987, the VA has addressed the problems of homelessness among veterans through the development of specialized programs. With the passage of Public Laws 110-71 and 110-6, the VA implemented the Domiciliary Care for Homeless Veterans (DCHV) and the Homeless Chronically Mentally Ill (HCMI) Veterans Programs (now a component of the larger Health Care for Homeless Veterans (HCHV) Program – see below).

Domiciliary Care for Homeless Veterans (DCHV) – 35 sites

This program provides medical care and rehabilitation in a residential setting on VA medical center grounds to eligible ambulatory veterans disabled by medical or psychiatric disorders, injury or age, who do not need hospitalization or nursing home care. In FY1999, there were 1791 operational beds available through the program at 35 VA medical centers in 26 states. (See Appendix E for directory of state contacts for DCHV.) The program provided residential treatment to some 5491 homeless veterans in FY1999. The mission and goals of the DCHV Program are to: 1) reduce homelessness; 2) improve the health status, employment performance and access to basic social and material resources among veterans, and; 3) reduce overall use of VA inpatient and domiciliary care services. Basic services provided by the program include:

1. *outreach* to identify underserved veterans among homeless persons encountered in soup kitchens, shelters and other community locations;
2. time-limited *residential treatment* that offers *medical and psychiatric services* including *substance abuse treatment and sobriety maintenance* as well as *social-vocational rehabilitation*, including work-for-pay programs at most sites (e.g., VA's Compensated Work Therapy or Incentive Work Therapy Programs – see below); and
3. *post-discharge community support* and aftercare.

Health Care for Homeless Veterans (HCHV) Program – 134 sites

The VA also funds a variety of programs specifically for homeless veterans through the Strategic Healthcare Group for Mental Health Services located in the Veterans Health Administration Headquarters. Collectively these programs are known as the Health Care for Homeless Veterans (HCHV) Program. Beginning in 1987 with the Homeless Chronically Mentally Ill (HCMI) program, HCHV programs now cover a continuum of services including: outreach; linkage with health and benefits programs; day programs; and housing in transitional and permanent settings supported by services and work opportunities. Using several different

funding mechanisms, the VA has strongly encouraged community collaborations as the foundation for assuring appropriate and adequate services for homeless veterans.

HCHV programs can be found in 134 locations nationwide, with configurations ranging from sites with a single component in some locations to a full range of services in eight sites designated as Comprehensive Homeless Centers. In addition, seven locations have outreach programs based on the HCHV model that are funded by the VISNs, rather than the SHGMHS. (See Appendix F for a list of the 86 HCHV locations as of September 1999, and the service components offered in each.)

Outreach is central to the philosophy and practice of the HCHV program. “The central goal of the HCHV program is to reduce homelessness among veterans by conducting outreach to those who are not currently receiving services and engage them in treatment and rehabilitative programs.”^{xxxviii}

The following descriptions of the various components under the general umbrella of the HCHV program were drawn from the VA website at www.va.gov/health/homeless/grants.htm or from the 13th Annual Report of the HCHV Programs, prepared by the VA’s Northeast Program Evaluation Center.^{xxxix}

➤ ***Homeless Chronically Mentally Ill Program (HCMI) – 64 sites***

The Homeless Chronically Mentally Ill (HCMI) program, established in 1987 as the original HCHV program component, offers extensive outreach, physical and psychiatric health exams, treatment, referrals, and ongoing case management to homeless veterans with mental health problems, including substance abuse. As appropriate, the HCMI program places homeless veterans needing longer-term treatment into one of its 200 contract community-based facilities. During FY99, this program assessed more than 29,000 veterans, with 4,000 receiving residential treatment in community-based treatment facilities. The average length of stay in community-based residential care is about 70 days. In FY99, over one-half of the discharges from residential treatment were considered successful.

➤ ***HUD/VA Supported Housing Program (HUD-VASH) – 35 sites***

This joint program – established in 1992 with the Department of Housing and Urban Development (HUD) – provides permanent housing and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. HUD’s Section 8 Voucher Program has designated 1,780 vouchers worth \$44.5 million for homeless chronically mentally ill veterans, and VA staff at 35 sites provide outreach, clinical care and case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans plagued by serious mental illness and substance abuse disorders.

Between FY92 and FY98, eligibility for HUD-VASH was determined by the following screening criteria:

1. must be homeless for 30 or more days prior to their initial contact with the HCMI or DCHV program, and living in a shelter or on the street at the point of the initial contact with that program;
2. must have a major substance abuse or psychiatric disorder resulting in significant disability;
3. must be clinically stabilized prior to participation in the program;
4. must demonstrate an interest in changing his or her lifestyle and in returning to work or to some other socially productive activity; and
5. must be prepared to make a long-term commitment to participate in a VA program of community-based treatment, rehabilitation and supported housing.

Since FY98, failure to meet some of these criteria may lower priority for program entry, but does not strictly prevent it.

➤ ***VA Supported Housing Program - 26 sites***

This program is like the HUD-VASH program in that VA staff help homeless veterans secure long-term transitional or permanent housing and offer ongoing case management services to help them remain in housing at a low cost the veteran can afford. It differs from HUD-VASH in that dedicated Section 8 housing vouchers are not available to homeless veterans in the program. VA staff work with private landlords, public housing authorities and nonprofit organizations to find creative housing arrangements. Veterans service organizations have been instrumental in helping VA establish these housing alternatives nationwide. In 1999, VA staff at 26 Supported Housing Program sites helped homeless veterans find 2031 transitional or permanent beds in the community.

Supported Housing programs may consist of permanent or transitional housing, with some program sites offering both. Even in transitional housing, veterans in this program are often expected to pay rent., which may be subsidized or discounted. Some Supported Housing programs have partnered with non-profit agencies who receive HUD Section 8 vouchers through the Shelter Plus Care program. With VA clinicians providing the case management, this is very similar to the HUD-VASH program described above.

Supported Housing case management services are designed to reintegrate veterans into community living. In addition to helping find a place to live, VA clinicians in this program help veterans re-learn daily living skills such as budgeting, shopping and cleaning. They help veterans find jobs, maintain good relationships with neighbors, and re-establish relationships with their families. Although sometimes direct psychotherapeutic or substance abuse counseling is offered, usually the veteran is encouraged to participate in other clinics at the VA Medical Center which offer these services.

➤ ***Compensated Work-Therapy (CWT) – 101 sites***

The VA's Compensated Work-Therapy (CWT) program (also known as "Veterans Industries") offers structured work opportunities to at-risk and homeless veterans with physical, psychiatric and substance abuse disorders. The VA contracts with private industry and the public sector for work to be done by these veterans, who learn new job skills, re-learn successful work habits and regain a sense of self-esteem and self-worth. Currently there are more than 100 individual CWT operations connected to VA medical centers nationwide. Nineteen sites are designed specifically for homeless veterans.

For more information on Compensated Work Therapy, go to www.va.gov/vetind/, or contact Frederick Lee, Planning Specialist, 590/302/116D Bldg 148, VA Medical Center, Hampton, Virginia 23667; Phone: (757-722-9961 Ext. 3624; E-mail: Frederick.Lee@med.va.gov.

➤ ***Compensated Work-Therapy/Transitional Residence (CWT/TR) – 31 sites***

The Compensated Work Therapy /Transitional Residence Program (CWT/TR) is a work-based Psychosocial Residential Rehabilitation Treatment Program (PRRTP) offering a therapeutic residential setting for veterans involved in Veterans Industries/Compensated Work Therapy (VI/CWT). This program provides a rehabilitation-focused residential setting for veterans recovering from chronic mental illness, chemical dependency and homelessness.

CWT/TR provides a bridge between hospitalization or intensive outpatient treatment and successful community reintegration. The program utilizes a residential therapeutic community of peer and professional support, with a strong emphasis on increasing personal responsibility and achievement of individualized rehabilitation goals. CWT/TR differs from other VA-operated residential bed programs in that participants contribute (using their VI/CWT earnings) to the cost of operating and maintaining their residences and are

responsible for planning, purchasing and preparing their own meals. The average length of stay is approximately six months.

More information on transitional residence is available from Jamie R. Ploppert, Program Specialist, 590/302/116D Bldg 148, VA Medical Center, Hampton, Virginia 23667; Phone: (757) 722-9961 Ext. 1123; Fax: (757) 728-3143; E-mail: Jamie.Ploppert2@med.va.gov.

➤ ***Drop-In Centers – 11 sites***

These “daytime sanctuaries” provide homeless veterans who sleep in shelters or on the streets at night with a safe environment during the day. Eleven centers offer therapeutic activities and programs to improve daily living skills, meals, and a place to shower and wash clothes. At these VA-run centers, veterans also participate in other VA programs that provide more extensive assistance, including a variety of therapeutic and rehabilitative activities. Linkage with long-term assistance is also available.

➤ ***VBA-VHA Special Outreach and Benefits Assistance – 12 sites***

The Veterans’ Health Administration (VHA) has provided specialized funding to support 12 Veterans Benefits Counselors as members of HCMI and Homeless Domiciliary Programs as authorized by Public Law 102-590. These specially-funded program staff provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible veterans applying for VA benefits. This initiative complements Veterans’ Benefits Assistance (VBA) offices’ ongoing efforts to target homeless veterans for special attention. To reach more homeless veterans, designated homeless veterans coordinators at the 58 regional offices of the VBA annually make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with homeless people, to provide over 24,000 homeless veterans with benefits counseling and referrals to other VA programs. These special outreach efforts are assumed as part of ongoing duties and responsibilities. The Homeless Eligibility Clarification Act enables eligible veterans without a fixed address to receive VA benefits checks at VA regional offices. VBA also has procedures to expedite the processing times for homeless veterans’ benefits claims.

➤ ***Joint Social Security Administration (SSA)/VA Pilot Project – 4 sites***

In this pilot project with the Social Security Administration (SSA), HCMI and Homeless Domiciliary staff coordinate outreach and benefits certification with SSA staff to increase the number of veterans receiving SSA benefits and otherwise assist in the rehabilitation. In this demonstration project, both applications and benefits awards have increased significantly and the time to process applications has decreased dramatically.

➤ ***VA Excess Property for Homeless Veterans Initiative***

This initiative provides for the distribution of federal excess personal property, such as clothing, footwear, socks, sleeping bags, blankets and other items to homeless veterans through VA domiciliaries and other outreach activities. In seven years, this initiative has been responsible for the distribution of more than \$90 million worth of materiel and currently has more than \$8 million in inventory. A CWT program employing formerly homeless veterans has been established at the VA Medical Center in Lyons, NJ, to receive, warehouse and ship these goods to VA homeless programs across the country.

What resources are available from the VA for community-based organizations that serve homeless veterans?

➤ ***Homeless Providers Grant and Per Diem Program***

This program provides grants and per diem payments to assist public and nonprofit organizations to establish and operate new supportive housing and service centers for homeless veterans with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Grant funds may also be used to assist organizations in purchasing vans to conduct

outreach or provide transportation for homeless veterans. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling, etc.) are eligible for these funds. The program has two levels of funding: the Grant portion and the Per Diem portion.

Grants: The limit for grants is 65% of the costs of constructing, expanding, remodeling, or altering buildings and acquiring facilities for use as service centers, transitional housing or other facilities for homeless vets. Remodeling or expanding VA properties is allowed; acquiring VA properties is not. Recipients must fund the matching 35% share. Grants may not be used for operational costs, including salaries.

Per Diem: Priority in awarding the Per Diem funds goes to the recipients of Grants. Non-Grant programs may qualify if: (1) at least 75% of those receiving supportive services are veterans; and (2) the program provides supportive housing or a homeless service center. Operational costs, including salaries, may be funded by the Per Diem program. Funding for services in conjunction with supportive housing is limited to half the cost of providing the services up to a predetermined amount. At this time, the maximum amount payable under per diem is \$19.00. Funding for a service center not in connection with supportive housing is limited to \$1.10 for each half-hour during which services are provided, up to \$17.60 a day per veteran. Veterans in supportive housing may be asked to pay rent if it does not exceed 30% of the veteran's monthly-adjusted income. In addition, "reasonable" fees may be charged for services not paid with Per Diem funds.

During the last seven rounds of funding, more than 800 applications were received, requesting approximately \$214 million to acquire, renovate, or construct supportive housing or service center facilities for homeless veterans or to purchase vans for outreach and transportation. In FY94 through FY00, 243 grants were awarded in 44 states and the District of Columbia. Total VA funding for these projects was over \$53 million. When these projects are completed, approximately 5,000 new community-based beds will be available for homeless veterans. Additionally under this funding, 17 independent homeless veterans service centers will be established; 85 vans will be purchased by entities to conduct outreach or provide transportation for homeless veterans; and five mobile service center units will be put in service to provide medical care and/or counseling for homeless veterans with limited access to treatment.

Applications are not accepted until the Notice of Funding Availability (NOFA) is published, which usually occurs between January and March for the Grant portion of the program. A separate "Per Diem Only" NOFA could be offered at other times depending on fund availability. Funds will be awarded to programs determined to be the most qualified. The Grant/Per Diem Program rules and regulations are codified at 38 CFR section 17.700.

For information on applying for this program, go to www.va.gov/health/homeless/grants.htm. The contact person is Roger Casey, VA Homeless Providers Grant and Per Diem Program, Mental Health Strategic Healthcare Group (116E), VACO, 810 Vermont Avenue, NW, Washington, DC 20420; (202) 273-8442 or (toll-free): 1-877-332-0334; e-mail: roger.casey@mail.va.gov.

➤ ***Loan Guarantee Program for Homeless Veterans Multifamily Housing***

This initiative authorizes the VA to guarantee up to 15 loans with an aggregate value of \$100 million within five years for construction or rehabilitation of multifamily transitional housing for homeless veterans. Loans may include amounts to acquire land, refinance existing loans, finance acquisition of furniture, equipment, supplies and materials, and supply working capital for the organization. No more than 5 loans may be guaranteed under this program prior to November 11, 2001. The amount financed is a maximum of 90% of project costs. Legislation allows the Secretary to issue a loan guarantee for large-scale self-sustaining multifamily loans. Eligible transitional projects are those that:

1. provide supportive services including job counseling;
2. require the veteran to seek and maintain employment;
3. require the veteran to pay reasonable rent;
4. require sobriety as a condition of occupancy; and
5. serve other veterans in need of housing or homeless people who are not veterans on a space available basis.

More information on this program is available at www.va.gov/health/homeless/multifamily.htm or contact VHACOMFH@hq.med.va.gov.

➤ ***Acquired Property Sales for Homeless Providers Program***

This program makes available properties VA obtains through foreclosures on VA-insured mortgages for sale to homeless provider organizations at a discount of 20 to 50%. To date, 173 properties have been sold to nonprofit organizations to provide housing for people who are homeless. For more information, contact the VA's Homeless Veterans Programs Office at (202) 273-5764 or send e-mail to homelessvets@mail.va.gov.

What new homeless initiatives have been funded by the VA for FY2000?

- ***Homeless Women Veterans Program.*** Eleven VA facilities will implement a specialized program that will focus on outreach, case management and community residential care for homeless women veterans and homeless women veterans with children.
- ***Therapeutic Employment Placement and Support (TEPS).*** Ten VA sites will implement a specialized program focusing on immediate permanent employment for homeless veterans who are dually diagnosed with mental illness and substance abuse disorders.
- ***Critical Time Intervention (CTI) Staff Training.*** VA has funded eight facilities to implement an intense but time limited case management program for hospitalized homeless veterans.
- ***Oral Health (Dental) Care for Homeless Veterans.*** VA has provided funding to ten VA facilities to implement an oral health care (dental) program for homeless veterans engaged in rehabilitation. Services will be provided through contracts with community based dental care programs.

7 Critical Access Issues

Obstacles to access faced by homeless veterans

[In these focus groups] veterans self-reported a high incidence of health and mental health problems, limited resources, negative public perceptions and treatment, insensitive service providers, dehumanizing policies and procedures, and high levels of stress and frustration with the service delivery system. They encountered personal, situational, and bureaucratic barriers to obtaining services and were highly critical of service providers.^{xi}

Steven Lozano Applewhite
“Homeless Veterans: Perspectives on Social Services Use”
Social Work

How many homeless veterans use VA services?

Despite the apparent availability of VA programs for homeless veterans described in the previous chapters, research to date continues to indicate that many homeless veterans are not being reached.

Fifty-seven percent of the currently homeless veterans interviewed for the 1999 Urban Institute study^{xli} reported having used a medical facility operated by the VA for overnight hospital care, outpatient visits, or for nursing home, convalescent home, or admissions for long-term care. A different study focusing specifically on homeless veterans with mental illness found similar results – 56% of those surveyed had used VA services at some point, with medical services being most often reported.^{xliii}

The Urban Institute study also found, however, that only 25% of the homeless veterans interviewed had participated in a program specifically for homeless veterans. Participation in these specialized programs was as follows:

TABLE 9 – Utilization of Homeless Veteran Programs
National Survey of Homeless Assistance Providers and Clients – Urban Institute (1999)

Homeless Veteran Program	N=676
Compensated work therapy program	8%
Domiciliary care program	11%
Homeless shelters for veterans not run by VA	14%
Veterans Center drop-in program	4%
Stand Down	4%
Other program	3%

What factors prevent easy access to care?

A variety of issues limit homeless veterans' use of VA and other services:

➤ *Geographic Access*

The VA's mainstream medical services are utilized more by homeless veterans than the VA's targeted homeless programs. The most obvious reason is the greater geographic availability of VA medical centers around the country. While they have increased significantly over the past decade (and have increased even since the Urban Institute survey was implemented), the targeted HCHV programs are still located in a limited number of communities.

Together with eligibility, geographic location was found to be an important determinant of access in the study with mentally ill homeless veterans. After examining use of VA services according to predisposing factors (demographic characteristics and wartime service), illness factors (type of medical problem and need for care), and enabling factors (entitlement to VA medical services and location of VA facilities), it was found that "veterans most likely to use VA services were those who received VA benefits that gave them priority access to VA services and those who lived near a VA medical center."^{xliii}

In those communities where there are no VA services available, homeless health care providers serving veterans are faced with making a choice of whether to encourage the client to relocate to a city with VA services, or to just use what is available locally.

➤ *Eligibility Issues*

Eligibility requirements limit access to programs, both at the system level and at the program level. Some eligibility requirements are based on a system-wide policy, e.g., honorable discharge status as a criterion for access to any VA program. Other eligibility requirements result from mandates to serve particularly vulnerable populations, or because limited resources and capacity force programs to target their services to specific priority groups (e.g., mentally ill veterans or women). As long as resources continue to be scarce, many veterans who do not fit into those special categories will be unable to access the services they need.

Extensive evaluation of the VA's homeless programs by the Northeast Program Evaluation Center (NEPEC) has resulted in a rich source of data and information for identifying elements that impact on the effectiveness of certain models. For example, NEPEC's evaluation of the HUD-VASH program identified the limitations imposed by strict eligibility and limited capacity. The evaluators concluded that those veterans who were admitted were served well by the intensive case management and long-term support offered by the program, "but at a cost of limited population coverage."^{xliv}

➤ *Lack of Appropriate and Comprehensive Services*

[The homeless veterans in the focus group] portrayed the VA system and other service delivery systems as lacking comprehensiveness and fairness in meeting the pressing needs of diverse cohorts of veterans who differ by age, gender, medical conditions, and mental health problems.^{xlv}

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Reflecting trends in the larger health care environment, the change from an inpatient orientation to an outpatient focus in the VA has had an effect on homeless veterans. "The extensive closure of substance abuse and, to a lesser extent, psychiatric beds in VA during the past four years, not surprisingly reduced the

availability of these service to numbers of homeless veterans that had used them. While VA's bed closures were based, in part, on recent clinical studies that indicated little differences in outcome for patients treated in inpatient or outpatient settings, it should be noted that these studies did not include homeless patients."^{xlvi}

One of the most common themes in describing the unique nature of providing care to people who are homeless is that housing – whether emergency, transitional or permanent – has to be part of the prescription for treatment. Without a stable place to live while involved in treatment, people without homes are far less likely to improve. Residential programs can address the psychiatric and addictions treatment issues, as well as helping to break down the social isolation that is also a contributor to homelessness. Although this has been recognized and implemented in the VA homeless programs, capacity is still limited as described above.

➤ ***Attitudes of Homeless Veterans***

Many homeless veterans have issues about service providers in general, about the VA, about large institutions or government, and about “red-tape” bureaucracies and lack of coordination of services. Many are resentful about not receiving services and benefits to which they feel they are entitled. This can even affect their attitudes about being seen by “foreign” doctors whom they perceive as receiving more assistance in this country as immigrants than they have themselves as veterans.^{xlvii} Many veterans also pride themselves on their ability to maintain self-reliance and to survive, often resulting in a preference for camping out rather than staying in shelters. At the same time, there is often an underlying negative self-esteem, attributed to “a multitude of setbacks in both personal and social interactions, such as the severing of familial ties, the loss of peer support, and the loss of autonomy and self-sufficiency.”^{xlviii}

Veterans in the focus groups from which the comments of this section were drawn identified three categories of barriers to acquiring services, whether in the community or from the VA: insensitive service providers, negative policies, and an ineffective service delivery system.^{xlix}

➤ ***Provider Attitudes***

In describing their experiences, veterans in Applewhite's focus groups noted that “one of their most pressing concerns related to insensitive service providers. Their experiences included lack of respect for their human dignity, apathy, indifference, callousness, service-connected labeling, degrading comments, and put-downs.”^{li} This is unacceptable whether it occurs in large institutions or small service agencies. In every organization there is a constant need for vigilance to assure that service providers stay human, compassionate, well-informed and culturally competent. Providers who are “burnt out” or jaded are certainly not helping their clients, or themselves.

➤ ***System Complexity***

For many veterans, the service delivery system is a maze of bureaucratic policies and procedures that operate as ‘buffer zones’ or ‘filtering systems’ designed to delay, if not prevent, veterans from obtaining needed services. For example, they discussed policies or practices that covertly discriminate on the basis of age, race, or physical disabilities. They identified other barriers such as cumbersome rules and regulations that serve only to dehumanize individuals, narrow eligibility criteria that systematically eliminate veterans from receiving services, and bureaucratic red tape that can discourage and degrade clients rather than enable them to secure services...According to veterans, ‘the system’ was designed to meet its own bureaucratic needs rather than those of homeless veterans”^{li}

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As this country's health care system evolves, many changes are designed for cost-savings or efficiency, often at the expense of simplicity. This is true for the VA health system as well. Many homeless health care providers have commented on the complicated nature of the VA eligibility system, both for benefits and for enrollment for health care services. Few homeless veterans are able to navigate these waters without a great deal of assistance. Social workers, outreach workers and case managers can help bridge those waters and hopefully connect the homeless veteran with a guide within the VA system. HCHV outreach programs are especially valuable for that purpose.

➤ ***Coordination and Capacity Issues***

According to homeless veterans, services are often difficult to obtain because the delivery system is unwieldy, inadequate, and inaccessible. They described the delivery system as a complex maze of programs and services with limited resources, staff that are excessively spread out, and inadequate funding to effectively address the severe problems facing homeless veterans.^{lii}

Steven Lozano Applewhite
“Homeless Veterans: Perspectives on Social Services Use”
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The concerns expressed by homeless veterans related to coordination, limited resources, insufficient staffing and inadequate funding, are concerns of most homeless health care providers as well. It is the responsibility of those providing health care to homeless veterans to stay informed of what other services are available in their community for homeless veterans and to actively pursue opportunities for informal or formal collaboration with those entities. Advocating for changes in the system, including increased resources and funding, is also a part of that responsibility. (See Chapter 9 on Collaboration and Advocacy.)

8 Non-VA Resources

Services for homeless veterans outside the VA system

What can be done for homeless veterans who are not eligible for VA services?

For various reasons – some discussed in the previous chapter – there are still many homeless veterans who will not be able to take advantage of the resources available from the VA. The response is simple and straightforward. **Homeless health care projects can and should treat these individuals as they would any of their non-veteran clients.** The primary difference is in the absence of those additional resource options offered by the VA.

As discussed in the chapter on health conditions, except for some of the specific service-related conditions that may be experienced by veterans, their other mental health and physical health needs are basically the same as those of other homeless people. Studies have shown that because of these similarities, homeless veterans will also benefit from programs designed for homeless people who are not veterans.

For homeless veterans with disabilities who are not eligible for VA benefits or services due to their discharge status, eligibility should be explored for all other possible entitlements and benefits. Many may be eligible for SSI or SSDI benefits (see Chapter 5 for SSA resources), and/or for Medicaid or indigent care programs operated by the county or state.

How can the veteran identity be used to support positive use of services?

Although homeless veterans as a group are similar in many ways to other homeless people, every individual has certain preferences, past experiences, values and beliefs that will either prevent effective use of services, or will act as motivation to engage in services that support positive changes. Just as non-veterans who are homeless may benefit from the support of other individuals with whom they share common bonds or characteristics (e.g., women who have suffered domestic violence, homeless individuals with non-mainstream sexual orientation, specific cultural or language groups, etc.), homeless veterans may benefit from the opportunity to affiliate with other veterans, either in support groups or within specialized programs.

[In these focus groups]...homeless veterans described a health and social services system fraught with insensitive providers, bureaucratic obstacles, and internal problems that make it difficult, if not impossible, for agencies to meet the growing demand for client services. They concluded that these problems force homeless veterans to develop informal support systems and life-coping skills to survive on the streets.^{liii}

Steven Lozano Applewhite
“Homeless Veterans: Perspectives on Social Services Use”
Social Work

These informal support systems and life-coping skills should be considered assets upon which to build appropriate services. Staff in homeless health care programs should attempt to locate existing programs and/or support groups for homeless veterans operated by VSOs or other local veteran-run organizations that are not affiliated with or subject to VA eligibility requirements. If these programs or groups do not already exist in the community, the homeless health care organization itself may want to consider facilitating the development of such groups with the veterans they serve.

Some research has shown that veterans considered the treatment environments in the all-veteran, VA-based DCHV program to be more “active” than those of the mixed-population HCMI program. This may reflect the special value of concentrated support for a positive veteran identity, which would also exist in mutual-aid programs run by VSOs.^{liv}

Can eligible veterans who are not using the VA system be engaged in those services?

“It is well-documented that poor people often do not feel as though they have a right to, or are entitled to the same benefits as others....[F]ostering a sense of such entitlement provides a powerful incentive for them to use needed services.”^{lv}

For those homeless veterans who are outside the VA system because of either lack of awareness or perceived barriers that are described above, “the VA movement to provide outreach assistance to homeless veterans through special mobile teams can be expected to facilitate the use of VA services both by increasing this sense of entitlement and by improving accessibility. VA initiatives may also be able to increase awareness among non-VA providers about eligibility for VA services.”^{lvi}

Two final comments from research by Rosenheck and colleagues reiterate the value of veteran-focused programs to engage homeless veterans in services:

...many homeless veterans place a high value on their access to VA and other veterans’ programs in which specialized services are available for disorders that are clearly specific to the veteran experience, particularly post-traumatic stress disorder. Homeless male veterans experience a strong and positive identify as veterans, and a previous study showed that those with combat experience are especially likely to seek out VA services.^{lvii} Veterans in VA or other veteran-specific homeless programs may also derive special benefit from the solidarity that comes from their shared past experiences.^{lviii}

Robert Rosenheck and Paul Koegel
“Characteristics of Veterans and Nonveterans
in Three Samples of Homeless Men”
Hospital and Community Psychiatry

...veteran status, and especially wartime service, may play an important role in treatment and rehabilitation. Virtually all homeless people must overcome demoralization and self-doubt as they attempt to rebuild their lives. Military service was a time of effective functioning for many veterans, and even more important, a time they recall with pride, particularly if they coped successfully with severe hardships. Clinical programs that tap and enlarge this reservoir of pride can both enhance participation in treatment and increase the likelihood of exiting homelessness.^{lix}

Robert Rosenheck, et al
“Homeless Veterans”
Homelessness in America

9 Collaboration & Advocacy

Improving access to care for homeless veterans

What opportunities exist for collaborating with VA homeless programs on planning and increasing access for homeless veterans?

Homeless health care providers must make every effort to assure involvement of representatives from the VA in local and statewide planning processes, either through the Continuum of Care or through strategic planning of homeless and housing coalitions. With the high degree of change and competition in the health care market today, it would also be wise to involve the VA in health care planning activities, especially in relation to primary care. Homeless people are often losers when health care access issues are left to the priorities of the market place. Conscious collaborative planning, as well as critical evaluation, are essential for designing systems that will truly meet the special needs of homeless people.

Two specific initiatives that involve collaboration are encouraged throughout the VA system – Project CHALENG and Stand Downs, each of which is described below.

➤ **Project CHALENG for Veterans** *(Taken from the VA's FY1999 Report on CHALENG^{lx})*

In 1992, the VA began Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans, an innovative program designed to enhance the continuum of care for homeless veterans between the VA and other available community services. The guiding principal behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless veterans move from homelessness to being productive members of society. Project CHALENG enhances coordinated services by bringing the VA together with community agencies who provide services to the homeless to raise awareness of homeless veterans' needs and to plan to meet those needs. This process helps eliminate duplicated services and improves homeless veterans' access to both the VA and other community agencies.

The legislation guiding this initiative is contained in Public Laws 102-405, 103-446 and 105-114. The specific legislative requirements relating to Project CHALENG are that local medical center and regional office directors:

- assess the needs of homeless veterans living in the area
- make the assessment in coordination with representatives from state and local governments, appropriate federal departments and agencies and non-governmental community organizations that serve the homeless population
- identify the needs of homeless veterans with a focus on health care, education and training, employment, shelter, counseling, and outreach
- assess the extent to which homeless veterans' needs are being met
- develop a list of all homeless services in the local area
- encourage the development of coordinated services
- take action to meet the needs of homeless veterans
- inform homeless veterans of non-VA resources that are available in the community to meet their needs

At the local level, VA medical centers and regional offices designate CHALENG Points of Contact (POCs) who are responsible for the above requirements. While these POCs work with local agencies throughout the year to coordinate services for homeless veterans, the annual assessment of homeless veterans' needs is made through a survey which is distributed at a CHALENG meeting attended by VA staff, local agency staff, and homeless or formerly homeless veterans.

Anyone working in homeless health care should make sure that they connect with the POC in their area to become involved in the CHALENG process, as well as assuring that the POC and any other appropriate VA staff are involved in other local coalition efforts that address the needs of homeless people in general.

A list of POCs is available in Appendix J. You can obtain further information by contacting Dr. Craig Burnette at Craig.Burnette1@med.va.gov or Jim McGuire at (310) 478-3711, x 41450.

➤ **Stand Downs**

(Taken from a brochure of the National Coalition for Homeless Veterans)

What is a Stand Down?

In times of war, exhausted combat units requiring time to rest and recover were removed from the battlefields to a place of relative security and safety. Today, Stand Down refers to a grassroots, community-based intervention program designed to help the nation's estimated 275,000 homeless veterans "combat" life on the streets. The *hand up, not a handout* philosophy of Stand Down is carried out through the work of hundreds of volunteers and organizations throughout the nation.

What is the history of Stand Down?

The concept of Stand Down, as related specifically to the homeless veteran crisis, was the brainchild of two Vietnam veterans, Robert VanKeuren and Dr. Jon Nachison. The first Stand Down was held in San Diego during the summer of 1988. The popularity of the event has steadily grown from the original in 1988 to over 200 yearly throughout the nation. It is estimated that as many as 100,000 homeless veterans have received assistance at Stand Downs.

What happens at a Stand Down?

Hundreds of homeless veterans are provided with a broad range of necessities including food, clothing, medical, legal and mental health assistance, job counseling and referral, and most importantly, companionship and camaraderie. It is a time for the community to connect with the homeless veteran population and address this crisis that affects each and every town, city and state in this country.

Who organizes and delivers these services?

Hundreds of caring volunteers and professionals give of their time and expertise to address the unique needs of homeless veterans. Committees formed specifically to put on the event stage most Stand Downs. Veteran service organizations, National Guard and Reserve Units, homeless shelter programs, health care providers, US Department of Veterans Affairs and Labor staffs, veteran-helping-veteran programs, and concerned citizens from the community organize and stage the events.

Where are Stand Downs held?

Stand Downs most often occur over a two or three day period, although there have been a handful of one day events. Some are held indoors, but the majority are held on football fields, parks or other wide-open spaces.

What does it take to stage a Stand Down?

There is no specific formula to plan and hold a Stand Down. In fact, each community adds its own uniqueness to a Stand Down. Some offer basic services, while others offer more by including entertainment and cultural activities in the agenda. Some Stand Downs are re-created to follow a regimented, military-style program, which is familiar and comforting to the veteran, and yet others create an atmosphere of empowerment to the extent of electing officers among the homeless veterans.

All it really takes for a community to organize a Stand Down is a group of dedicated volunteers committed to assisting homeless veterans to improve their situation. If there is not a Stand Down scheduled in a community near you, you could help organize a planning committee to assist the homeless veterans in your area.

For more information:

The National Coalition for Homeless Veterans maintains an active list of scheduled Stand Downs across the nation. An updated list is also available at www.va.gov/health/homeless/standdown.htm or from the Homeless Coordinator at your local VA Medical Center or VA Vet Center.

Additional resources regarding how to organize a Stand Down are included in:

1. *Stand Down Manual*, by Robert VanKeuren, Dr. Jon Nachison and Richard Talbott. Call Vietnam Veterans of San Diego at (619) 497-0142.
2. *Organizing a Stand Down*, published by Vietnam Veterans of America. Call (202) 628-2700.

What are some examples of how Health Care for the Homeless projects have developed partnerships with the VA to serve homeless veterans?

In some communities the VA's homeless programs operate independently of community-based providers. In others, the VA and other agencies have increased their impact by joining forces in the delivery of services. Following are some examples of how that can happen.

➤ **Albuquerque Health Care for the Homeless (HCH)
Albuquerque, NM**

(Excerpts from the Fall 2000 issue of El Intercambio, the newsletter of the Albuquerque HCH project)

In New Mexico, 25% of veterans use the VA as their primary source of health care, higher than in most states. However, HCH sees homeless veterans who are using no VA services. Half of the approximately 1,000 veterans seen by HCH each year have not accessed any services through the VA.

Part of HCH's strategy for ending homelessness is to provide care in the short-term, and work longer-term to help clients establish a medical home and access other resources as they move out of homelessness. A partnership with the VA in Albuquerque was initiated in the summer of 2000 to make this strategy work for homeless veterans. The VA Veterans Outreach Program (VOP) is a multidisciplinary team that works on-site at the HCH clinic two mornings per week, with laptops and cell phones to link them to VA records and screening and enrollment capabilities. In addition to clinic-based outreach, a VOP member accompanies one of the HCH mental health case managers on early morning outreach to camps and the streets.

The team consists of four full-time staff members – the VOP coordinator (a VA social worker), an RN (a combat veteran with 20 years experience as a VA psych nurse), a social worker/case manager, and a clerk – as well as four part-time staff, including an internal medicine physician, a psychiatrist, an addictions therapist and a vocational rehabilitation counselor. The VOP's objective is to find veterans who have never been or are barely in touch with the VA – whether due to bad experiences or limited knowledge of benefits and eligibility – and to link and reintegrate them to services.

Comments from HCH and VOP staff give testimony to the impact and value of this collaboration...

So many vets are caught up in or afraid of the VA bureaucracy – it can be like a monster... [But the HCH-VA collaboration is] a bridge, a fantastic idea... (by sending providers to) a more reachable level, vets are much more likely to use VA services...just the fact that they're reaching out, rather than asking vets to 'suit up and show up' makes a real big difference. – formerly homeless veteran who now runs the HCH Stepping Stones Drop-In Center for homeless substance abusers

[The VA presence at HCH] turned it around...some who stayed away from the VA are willing to seek care now. They have some resources that we don't and they've really opened up doors to care. It's so nice to be able to tell vets "there's a team here right now." – HCH nurse practitioner

[The VA nurse] has good rapport with people on the street...he was comfortable from the first day out. Not only is he an asset to the team, but the other resources he brings round out the volume and variety of supplies we need in the field. – HCH mental health case manager

We're learning from you guys...from your experience and expertise. – VOP nurse commenting on how moving from an institutional setting to a community-based organization reveals new approaches to on-the-spot problem solving to accomplish service goals

For more information on the HCH-VA collaboration in Albuquerque, contact Sally Popejoy, HCH Clinic Manager at (505) 242-4644.

➤ **El Centro Del Barrio
San Antonio, TX**

San Antonio has a large number of veterans and is the site of a VA Medical Center with a Health Care for Homeless Veterans (HCHV) program. The HCH program at El Centro Del Barrio (CDB) has collaborated with the VA's HCHV program for many years. The HCHV Program Director is a member of the HCH Advisory Council and the VA staff maintain membership in the local coalition of homeless service providers.

CDB is a federally-funded community health center which operates five HCH clinics to provide primary health care and social services to homeless people. One of these – the Dullnig House Clinic – is located adjacent to the Salvation Army Shelter where many homeless people, including veterans, congregate. Two VA outreach workers from the HCHV program, a nurse and a social worker, work on site at the Dullnig House Clinic every Tuesday morning to provide services to homeless veterans. HCH staff provide the work space and make direct referrals to them. Many homeless veterans go to the clinic on Tuesdays specifically because they know the VA workers are there. VA staff are also available on a rotating basis in some of the other shelter sites.

The HCHV program is seen as an essential referral resource for HCH clients, especially in the area of detox, housing and work programs, and halfway houses. At the same time, the HCH program also serves many homeless veterans, including some who need an alternative source of care, having “burned their bridges” with the HCHV program.

For more information on the collaboration between El Centro Del Barrio and the VA's HCHV program, contact Jay Sanchez, HCH Program Director, at (210) 229-9322.

➤ **Homeless Initiative Program (HIP)
Indianapolis, IN**

The Homeless Initiative Program (HIP) is a multidisciplinary effort composed of a primary medical care team, social workers for case management, street/community outreach workers, and an education/job placement team. The bulk of HIP services are offered off-site, at virtually every shelter and mission in Marion County. Collaboration with the VA has occurred in varying degrees since HIP was first initiated in the late 1980's. HIP case managers have always referred eligible clients to the VA's Homeless Team for specific services to veterans that only they can provide. For years, HIP has hosted a monthly meeting with the VA's outreach staff to share information and case conference needs of mutual clients.

Currently, HIP operates a Homeless Veteran's Reintegration Project, funded through a grant from the US Department of Labor, Veteran's Employment and Training. This grant enables HIP to assist veterans in finding and retaining employment and housing. The grant provides money for supportive services such as transportation to and from work; uniforms, boots and tools needed for the job; payment for temporary, stable housing and/or first month's rent; tuition for college classes or training to increase workforce skills. The VA Homeless Team refers veterans to HIP for employment and housing assistance, while continuing to provide case management and oversight for veterans' substance abuse and/or mental health issues. This arrangement encourages communication and collaboration, while discouraging duplication of services.

Another way that HIP/HVRP has collaborated with the VA is through support of the Stand Downs that are held three times a year. In 2000, the grant proposal was written with monetary support for recruitment and

publicity for the events. HIP/HVRP staff also assisted with set-up, staffed an information table on site, and provided two local sport “legends” for a one-on-one basketball demonstration that was enjoyed by all. Next year, HIP/HVRP will provide materials to give away to veterans at the Stand Downs.

The HIP/HVRP program also works with other agencies assisting with veterans in the community, including the DVOP/LVER staff at the Indianapolis Network for Employment & Training (iNET is the local employment/unemployment office), Disabled American Veterans, American Legion, and the VA Medical Center.

For more information on the HIP/HVRP program, contact Sharon Stark at (317) 931-3055.

➤ **Hudson River HealthCare Peekskill, NY**

Hudson River HealthCare (HRHCare) has a collaborative relationship with the Montrose VA Hospital that seeks to provide a continuum of health care for a variety of veterans in the Peekskill community. There is collaboration and communication around both clinical and supportive services. In terms of clinical care, HRHCare providers have established referral linkages with specialists practicing at the VA Hospital, so that patients can receive specialty care as appropriate, with reports and feedback coming back to the Health Center providers. With the patients’ permission, medical record information is shared with the hospital providers.

Collaboration around supportive services centers mostly around HIV-infected and at-risk veterans. The HRHCare peer educators go to the VA hospital on a regular basis to provide health education around HIV and AIDS to veterans in the VA’s outpatient programs, including their detox day treatment program. The Health Center works closely with the Hospital’s social work department to facilitate the participation of the Hospital’s patients in HRHCare support groups. This collaborative activity will also extend to commemoration of World AIDS Day next year, when a portion of the Health Center’s activities will take place at the VA Hospital.

Finally, the Hospital has provided the Health Center with a number of patients who volunteer at the Health Center’s community events. They provide services that include passing out health education literature, security, food preparation and distribution, and entertainment, as appropriate.

What opportunities exist for collaborating on advocacy for homeless veterans?

Homeless health care providers who are interested in increasing access for homeless veterans through advocacy and policy work should check with their local VSOs or national VSO offices and/or contact any of the following national organizations for more information:

National Coalition for Homeless Veterans (NCHV)

333 ½ Pennsylvania Avenue SE
Washington, DC 20003-1148
(202) 546-1969 or (800) VET-HELP
www.nchv.org

National Veterans Legal Services Project (NVLSP)

2001 S St. NW, Suite 610
Washington, DC 20009
Phone: (202) 265-8305
Fax: (202) 328—0063
www.nvlsp.org

National Alliance to End Homelessness (NAEH)

1518 K Street NW, Suite 206
Washington, DC 20005
Phone: (202) 638-1526
Fax: (202) 638-4664
www.naeh.org

National Coalition for the Homeless

1012 14th Street NW, Suite 600
Washington, DC 20005-3406
Phone: (202) 737-6444
Fax: (202) 737-6445
www.nationalhomeless.org

National Health Care for the Homeless Council

P.O. Box 60427
Nashville, TN 37206-0427
Phone: (615) 226-2292
Fax: (615) 226-1656
www.nhchc.org

END NOTES

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