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Medical

Veterans Benefits Administration

Supplement No. 47

Covering period of *Federal Register* issues through June 2, 2009

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Supplemental Materials for *Book I*

Code of Federal Regulations
Title 38, Parts 17, 46, 47, 51–53, 58–61, and 70

Medical

Veterans Benefits Administration

Supplement No. 47

5 June 2009

Covering the period of Federal Register issues
through June 2, 2009

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FILING INSTRUCTIONS

Book I, Supplement No. 47
June 5, 2009

Remove these old pages	*Add these new pages*	*Section(s) Affected*
Do not file this supplement until you confirm that all prior supplements have been filed		
17. 36-1 to 17.36-10	17. 36-1 to 17.36-8	§17.36
51.INDEX-1 to 51. INDEX –2	**51.INDEX-1 to 51. INDEX –2**	**Index to Part 51**
51.1-1 to 51.210-9	51.1-1 to 51.210-9	§§51.2, 51.20, 51.30, 51.40–51.43, 51.70, 51.80, 51.90, 51.100, 51.110, 51.120, 51.130, 51.150, 51.160, 51.180, 51.190, 51.200, 51.210.
58.INDEX-1 to 58. INDEX –2	**58.INDEX-1 to 58. INDEX –2**	**Index to Part 58**
58.10-1 to 58.10-2	58.10-1 to 58.10-2	Authority citation
58.11-1 to 58.14-1	58.11-1 to 58.14-1	§58.11–58.13
None	58.18-1 to 58.18-4	§58.18; add after page 58.17-1

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HIGHLIGHTS

Book I, Supplement No. 47
June 5, 2009

Supplement* Highlights *references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: "Supplement *Highlights* references—37(1)." This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 29 April 2009, the VA published a final rule, effective 29 May 2009, to amend regulations concerning payment of per diem to State homes providing nursing home care to eligible veterans by updating the basic per diem rate, implementing provisions of the *Veterans Benefits, Health Care, and Information Technology Act of 2006*, and making several other changes to better ensure that veterans receive quality care in State homes. Changes:

- In §51.2, revised definitions for *clinical nurse specialist* and *nurse practitioner*;
- In §51.20, revised paragraph (a);
- In §51.30, revised paragraphs (a)(1), (d), (e), and (f);
- Revised §51.40;
- Added new §§51.41–51.43;
- In §51.70, revised paragraph (c)(5);
- In §51.100, revised paragraph (h)(2);
- In §51.110, revised paragraph (b)(1)(i); removed paragraph (b)(1)(iii); redesignated paragraphs (d)–(e) as (e)–(f); and added a new paragraph (d);
- In §51.200, revised paragraphs (a) and (b);
- In §51.210, revised paragraph (b) introductory text;
- In §58.11, revised VA Form 10-5588;

- In §58.12, revised VA Form 10-10EZ and added new VA Form 10-10EZR;
- In §58.13, revised VA Form 10-10SH; and
- Added a new §58.18 and VA Form 10-0460.

2. On 15 May 2009, the VA published a final rule, effective 15 June 2009, to amend medical regulations regarding enrollment in the VA health care system in order to establish additional sub-priorities within enrollment priority category 8 and provide that beginning on the effective date of the rule, VA will begin enrolling priority category 8 veterans whose income exceeds the current means test and geographic means test income thresholds by 10 percent or less. Changes:

- In §17.36, revised paragraphs (b)(8), (c)(1)–(2), and (d)(1).

Reserved

Enrollment Provisions and Medical Benefits Package

§17.36 Enrollment—provision of hospital and outpatient care to veterans.

(a) *Enrollment requirement for veterans.*

(1) Except as otherwise provided in §17.37, a veteran must be enrolled in the VA healthcare system as a condition for receiving the "medical benefits package" set forth in §17.38.

Note to paragraph (a)(1): A veteran may apply to be enrolled at any time. (See §17.36(d)(1).)

(2) Except as provided in paragraph (a)(3) of this section, a veteran enrolled under this section and who, if required by law to do so, has agreed to make any applicable copayment is eligible for VA hospital and outpatient care as provided in the "medical benefits package" set forth in §17.38.

Note to paragraph (a)(2): A veteran's enrollment status will be recognized throughout the United States.

(3) A veteran enrolled based on having a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided in 38 U.S.C. 1710(e), is eligible for VA care provided in the "medical benefits package" set forth in §17.38 for the disorder.

(b) *Categories of veterans eligible to be enrolled.* The Secretary will determine which categories of veterans are eligible to be enrolled based on the following order of priority:

(1) Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

(2) Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.

(3) Veterans who are former prisoners of war; veterans awarded the Purple Heart; veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service-connected disabilities; veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; veterans who receive disability compensation under 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and veterans receiving compensation at the 10 percent rating level based on multiple noncompensable service-connected disabilities that clearly interfere with normal employability.

(4) Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound and other veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.

(5) Veterans not covered by paragraphs (b)(1) through (b)(4) of this section who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

(6) Veterans of the Mexican border period or of World War I; veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during 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, as provided and limited in 38 U.S.C. 1710(e); and veterans with 0 percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis.

(7) Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g) if their income for the previous year constitutes "low income" under the geographical income limits established by the U.S. Department of Housing and Urban Development for the fiscal year that ended on September 30 of the previous calendar year. For purposes of this paragraph, VA will determine the income of veterans (to include the income of their spouses and dependents) using the rules in §§3.271, 3.272, 3.273, and 3.276. After determining the veterans' income and the number of persons in the veterans' family (including only the spouse and dependent children), VA will compare their income with the current applicable "low-income" income limit for the public housing and section 8 programs in their area that the U.S. Department of Housing and Urban Development publishes pursuant to 42 U.S.C. 1437a(b)(2). If the veteran's income is below the applicable "low-income" income limits for the area in which the veteran resides, the veteran will be considered to have "low income" for purposes of this paragraph. To avoid a hardship to a veteran, VA may use the projected income for the current year of the veteran, spouse, and dependent children if the projected income is below the "low income" income limit referenced above. This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who are in an enrolled status on a specified date announced in a *Federal Register* document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(ii) Nonservice-connected veterans who are in an enrolled status on a specified date announced in a *Federal Register* document promulgated under paragraph (c) of this section and who subsequently do not request disenrollment;

(iii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(7)(i) of this section; and

(iv) Nonservice-connected veterans not included in paragraph (b)(7)(ii) of this section.

(8) Veterans not included in priority category 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g). This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(ii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(iii) Nonservice-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(iv) Nonservice-connected veterans not included in paragraph (b)(8)(iii) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(v) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) or paragraph (b)(8)(ii) of this section; and

(vi) Nonservice-connected veterans not included in paragraph (b)(8)(iii) or paragraph (b)(8)(iv) of this section.

(c) *Federal Register notification of eligible enrollees.*

(1) It is anticipated that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled. The Secretary at any time may revise the categories or subcategories of veterans eligible to be enrolled by amending paragraph (c)(2) of this section. The preamble to a *Federal Register* document announcing which priority categories and subcategories are eligible to be enrolled must specify the projected number of fiscal year applicants for enrollment in each priority category, projected healthcare utilization and expenditures for veterans in each priority category, appropriated funds and other revenue projected to be available for fiscal year enrollees, and projected total expenditures for enrollees by priority category. The determination should include consideration of relevant internal and external factors, e.g., economic changes, changes in medical practices, and waiting times to obtain an appointment for care. Consistent with these criteria, the Secretary will determine which categories of veterans are eligible to be enrolled based on the order of priority specified in paragraph (b) of this section.

(2) Unless changed by a rulemaking document in accordance with paragraph (c)(1) of this section, VA will enroll the priority categories of veterans set forth in §17.36(b) beginning June 15, 2009, except that those veterans in subcategories (v) and (vi) of priority category 8 are not eligible to be enrolled.

(d) *Enrollment and disenrollment process.*

(1) *Application for enrollment.* A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10-10EZ to a VA medical facility or via an Online submission at *https://www.1010ez.med.va.gov/sec/vha/1010ez/.*

(2) *Action on application.* Upon receipt of a completed VA Form 10-10EZ, a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will accept a veteran as an enrollee upon determining that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will inform the applicant that the applicant is ineligible to be enrolled.

(3) *Placement in enrollment categories.*

(i) Veterans will be placed in priority categories whether or not veterans in that category are eligible to be enrolled.

(ii) A veteran will be placed in the highest priority category or categories for which the veteran qualifies.

(iii) A veteran may be placed in only one priority category, except that a veteran placed in priority category 6 based on a specified disorder or illness will also be placed in priority category 7 or priority category 8, as applicable, if the veteran has previously agreed to pay the applicable copayment, for all matters not covered by priority category 6.

(iv) A veteran who had been enrolled based on inclusion in priority category 5 and became no longer eligible for inclusion in priority category 5 due to failure to submit to VA a current VA Form 10-10EZ will be changed automatically to enrollment based on inclusion in priority category 6 or 8 (or more than one of these categories if the previous principle applies), as applicable, and be considered continuously enrolled. To meet the criteria for priority category 5, a veteran must be eligible for priority category 5 based on the information submitted to VA in a current VA Form 10-10EZ. To be current, after VA has sent a form 10-10EZ to the veteran at the veteran's last known address, the veteran must return the completed form (including signature) to the address on the return envelope within 60 days from the date VA sent the form to the veteran.

(v) Veterans will be disenrolled, and reenrolled, in the order of the priority categories listed with veterans in priority category 1 being the last to be disenrolled and the first to be reenrolled. Similarly, within priority categories 7 and 8, veterans will be disenrolled, and reenrolled, in the order of the priority subcategories listed with veterans in subcategory (i) being the last to be disenrolled and first to be reenrolled.

(4) *Automatic enrollment.* Notwithstanding other provisions of this section, veterans who were notified by VA letter that they were enrolled in the VA healthcare system under the trial VA enrollment program prior to October 1, 1998, automatically will be enrolled in the VA healthcare system under this section if determined by a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will inform the veteran that the veteran is ineligible to be enrolled.

(5) *Disenrollment.* A veteran enrolled in the VA health care system under paragraph (d)(2) or (d)(4) of this section will be disenrolled only if:

(i) The veteran submits to a VA medical center or the VA Health Eligibility Center, 1644 Tullie Circle, Atlanta, Georgia 30329, a signed document stating that the veteran no longer wishes to be enrolled; or

(ii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran is no longer in a priority category eligible to be enrolled, as set forth in §17.36(c)(2); or

(iii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran has been enrolled based on inclusion in priority category 5 or priority category 7; determines that the veteran was sent by mail a VA Form 10-10EZ; and determines that the veteran failed to return the completed form to the address on the return envelope within 60 days from receipt of the form. VA Form 10-10EZ is set forth in paragraph (f) of this section.

(6) *Notification of enrollment status.* Notice of a decision by a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, regarding enrollment status will be provided to the affected veteran by letter and will contain the reasons for the decision. The letter will include an effective date for any changes and a statement regarding appeal rights. The decision will be based on all information available to the decisionmaker, including the information contained in VA Form 10-10EZ.

(e) *Catastrophically disabled.* For purposes of this section, catastrophically disabled means to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. This definition is met if an individual has been found by the Chief of Staff (or equivalent clinical official) at the VA facility where the individual was examined to have a permanent condition specified in paragraph (e)(1) of this section; to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a clinical evaluation of the patient's medical records that documents that the patient previously met the permanent criteria and continues to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment; or to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a current medical examination that documents that the patient meets the permanent criteria and will continue to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment.

(1) Quadriplegia and quadriparesis (ICD-9-CM Code 344.0x: 344.00, 344.01, 344.02, 344.03, 344.04, 3.44.09), paraplegia (ICD-9-CM Code 344.1), blindness (ICD-9-CM Code 369.4), persistent vegetative state (ICD-9-CM Code 780.03), or a condition resulting from two of the following procedures (ICD-9-CM Code 84.x or associated V Codes when available or Current Procedural Terminology (CPT) Codes) provided the two procedures were not on the same limb:

(i) Amputation through hand (ICD-9-CM Code 84.03 or V Code V49.63 or CPT Code 25927);

(ii) Disarticulation of wrist (ICD-9-CM Code 84.04 or V Code V49.64 or CPT Code 25920);

(iii) Amputation through forearm (ICD-9-CM Code 84.05 or V Code V49.65 or CPT Codes 25900, 25905);

(iv) Disarticulation of forearm (ICD-9-CM Code 84.05 or V Code V49.66 or CPT Codes 25900, 25905);

(v) Amputation or disarticulation through elbow. (ICD-9-CM Code 84.06 or V Code V49.66 or CPT 24999);

(vi) Amputation through humerus (ICD-9-CM Code 84.07 or V Code V49.66 or CPT Codes 24900, 24920);

(vii) Shoulder disarticulation (ICD-9-CM Code 84.08 or V Code V49.67 or CPT Code 23920);

(viii) Forequarter amputation (ICD-9-CM Code 84.09 or CPT Code 23900);

(ix) Lower limb amputation not otherwise specified (ICD-9-CM Code 84.10 or V Code V49.70 or CPT Codes 27880, 27882);

(x) Amputation of great toe (ICD-9-CM Code 84.11 or V Code V49.71 or CPT Codes 28810, 28820);

(xi) Amputation through foot (ICD-9-CM Code 84.12 or V Code V49.73 or CPT Codes 28800, 28805);

(xii) Disarticulation of ankle (ICD-9-CM Code 84.13 or V Code V49.74 or CPT 27889);

(xiii) Amputation through malleoli (ICD-9-CM Code 84.14 or V Code V49.75 or CPT Code 27888);

(xiv) Other amputation below knee (ICD-9-CM Code 84.15 or V Code V49.75 or CPT Codes 27880, 27882);

(xv) Disarticulation of knee (ICD-9-CM Code 84.16 or V Code V49.76 or CPT Code 27598);

(xvi) Above knee amputation (ICD-9-CM Code 84.17 or V Code V49.76 or CPT Code 27598);

(xvii) Disarticulation of hip (ICD-9-CM Code 84.18 or V Code V49.77 or CPT Code 27295); and

(xviii) Hindquarter amputation (ICD-9-CM Code 84.19 or CPT Code 27290).

(2) (i) Dependent in 3 or more Activities of Daily Living (eating, dressing, bathing, toileting, transferring, incontinence of bowel and/or bladder), with at least 3 of the dependencies being permanent with a rating of 1, using the Katz scale.

(ii) A score of 10 or lower using the Folstein Mini-Mental State Examination.

(iii) A score of 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure.

(iv) A score of 30 or lower using the Global Assessment of Functioning.

(f) *VA Form 10-10EZ.* [See 38 C.F.R. §58.12]

(Authority: 38 U.S.C. 101, 501, 1521, 1701, 1705, 1710, 1722)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0091.)

[64 FR 54212, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 67 FR 62887, Oct. 9, 2002; 68 FR 2672, Jan. 17, 2003; 74 FR 22834, May 15, 2009]

Supplement *Highlights* references: 37(1). Book I, 9(1), 12(1), 13(2), 47(2).

51.INDEX-1

Part 51

Per Diem for Nursing Home Care of Veterans in State Homes

Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

Source: 65 Fed. Reg. 968, January 6, 2000, unless otherwise indicated.

— Section Title Index —

51.INDEX-2

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Part 51

Per Diem for Nursing Home Care of Veterans in State Homes

Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

Source: 65 Fed. Reg. 968, January 6, 2000, unless otherwise indicated.

Subpart A — General

§51.1 Purpose.

This part sets forth the mechanism for paying per diem to State homes providing nursing home care to eligible veterans and is intended to ensure that veterans receive high quality care in State homes.

§51.2 Definitions.

For purposes of this part:

Clinical nurse specialist means a licensed professional nurse who has a Master's degree in nursing with a major in a clinical nursing specialty from an academic program accredited by the National League for Nursing and who is certified by a nationally recognized credentialing body (such as the National League for Nursing, the American Nurses Credentialing Center, or the Commission on Collegiate Nursing Education).

Facility means a building or any part of a building for which a State has submitted an application for recognition as a State home for the provision of nursing home care or a building or any part of a building which VA has recognized as a State home for the provision of nursing home care.

Nurse practitioner means a licensed professional nurse who is currently licensed to practice in the State; who meets the State's requirements governing the qualifications of nurse practitioners; and who is currently certified as an adult, family, or gerontological nurse practitioner by a nationally recognized body that provides such certification for nurse practitioners, such as the American Nurses Credentialing Center or the American Academy of Nurse Practitioners.

Nursing home care means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled nursing care and related medical services.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State.

Physician assistant means a person who meets the applicable State requirements for physician assistant, is currently certified by the National Commission on Certification of Physician Assistants (NCCPA) as a physician assistant, and has an individualized written scope of practice that determines the authorization to write medical orders, prescribe medications and other clinical tasks under appropriate physician supervision which is approved by the primary care physician.

Primary physician or *primary care physician* means a designated generalist physician responsible for providing, directing and coordinating all health care that is indicated for the residents.

State means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

State home means a home approved by VA which a State established primarily for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. A State home may provide domiciliary care, nursing home care, adult day health

care, and hospital care. Hospital care may be provided only when the State home also provides domiciliary and/or nursing home care.

VA means the U.S. Department of Veterans Affairs.

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.10

Reserved

Subpart B—Obtaining Per Diem for Nursing Home Care in State Homes

§51.10 Per diem based on recognition and certification.

VA will pay per diem to a State for providing nursing home care to eligible veterans in a facility if the Under Secretary for Health recognizes the facility as a State home based on a current certification that the facility and facility management meet the standards of subpart D of this part. Also, after recognition has been granted, VA will continue to pay per diem to a State for providing nursing home care to eligible veterans in such a facility for a temporary period based on a certification that the facility and facility management provisionally meet the standards of subpart D. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

Next Section is §51.20

§51.20 Application for recognition based on certification.

To apply for recognition and certification of a State home for nursing home care, a State must:

(a) Send a request for recognition and certification to the Chief Consultant, Office of Geriatrics and Extended Care (114), VA Central Office, 810 Vermont Avenue, NW., Washington, DC 20420. The request must be in the form of a letter and must be signed by the State official authorized to establish the State home;

(b) Allow VA to survey the facility as set forth in §51.30(c); and

(c) Upon request from the director of the VA medical center of jurisdiction, submit to the director all documentation required under subpart D of this part. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.30

§51.30 Recognition and certification.

(a) (1) The Under Secretary for Health will make the determination regarding recognition and the initial determination regarding certification, after receipt of a recommendation from the director of the VA medical center of jurisdiction regarding whether, based on a VA survey, the facility and facility management meet or do not meet the standards of subpart D of this part. The recognition survey will be conducted only after the new facility either has at least 21 residents or has a number of residents that consist of at least 50 percent of the new bed capacity of the new facility.

(2) For each facility recognized as a State home, the director of the VA medical center of jurisdiction will certify annually whether the facility and facility management meet, provisionally meet, or do not meet the standards of subpart D of this part (this certification should be made every 12 months during the recognition anniversary month or during a month agreed upon by the VA medical care center director and officials of the State home facility). A provisional certification will be issued by the director only upon a determination that the facility or facility management does not meet one or more of the standards in subpart D, that the deficiencies do not jeopardize the health or safety of the residents, and that the facility management and the director have agreed to a plan of correction to remedy the deficiencies in a specified amount of time (not more time than the VA medical center of jurisdiction director determines is reasonable for correcting the specific deficiencies). The director of the VA medical center of jurisdiction will notify the official in charge of the facility, the State official authorized to oversee the operations of the State home, the VA Network Director (10N 1-22), Chief Network Officer (10N) and the Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) of the certification, provisional certification, or noncertification.

(b) Once a facility has achieved recognition, the recognition will remain in effect unless the State requests that the recognition be withdrawn or the Under Secretary for Health makes a final decision that the facility or facility management does not meet the standards of subpart D. Recognition of a facility will apply only to the facility as it exists at the time of recognition; any annex, branch, enlargement, expansion, or relocation must be separately recognized.

(c) Both during the application process for recognition and after the Under Secretary for Health has recognized a facility, VA may survey the facility as necessary to determine if the facility and facility management comply with the provisions of this part. Generally, VA will provide advance notice to the State before a survey occurs; however, surveys may be conducted without notice. A survey, as necessary, will cover all parts of the facility, and include a review and audit of all records of the facility that have a bearing on compliance with any of the requirements of this part (including any reports from State or local entities). For purposes of a survey, at the request of the director of the VA medical center of jurisdiction, the State home facility management must submit to the director a completed VA Form 10-3567, Staffing Profile, set forth at §58.10 of this chapter. The director of the VA medical center of jurisdiction will designate the VA officials to survey the facility. These officials may include physicians; nurses; pharmacists; dietitians; rehabilitation therapists; social workers; representatives from health administration, engineering, environmental management systems, and fiscal officers.

(d) If, during the process for recognition and certification, the director of the VA medical center of jurisdiction recommends that the State home facility or facility management does not meet the standards of this part or if, after recognition and certification have been granted, the director of the VA medical center of jurisdiction determines that the State home facility or facility management does not meet the standards of this part, the director will notify the State home facility in writing of the standards not met. The director will send a copy of this notice to the State official authorized to oversee operations of the facility, the VA Network Director (10N 1-22), the Chief Network Officer (10N), and the Chief Consultant, Geriatrics and Extended Care (114). The letter will include the reasons for the recommendation or decision and indicate that the State has the right to appeal the recommendation or decision.

(e) The State must submit the appeal to the Under Secretary for Health in writing, within 30 days of receipt of the notice of the recommendation or decision regarding the failure to meet the standards. In its appeal, the State must explain why the recommendation or determination is inaccurate or incomplete and provide any new and relevant information not previously considered. Any appeal that does not identify a reason for disagreement will be returned to the sender without further consideration.

(f) After reviewing the matter, including any relevant supporting documentation, the Under Secretary for Health will issue a written determination that affirms or reverses the previous recommendation or determination. If the Under Secretary for Health decides that the facility does not meet the standards of subpart D of this part, the Under Secretary for Health will withdraw recognition and stop paying per diem for care provided on and after the date of the decision (or not grant recognition and certification and not pay per diem if the appeal occurs during the recognition process). The decision of the Under Secretary for Health will constitute a final decision that may be appealed to the Board of Veterans' Appeals (see 38 U.S.C. 7104 and 7105 and 38 CFR Part 20). The Under Secretary for Health will send a copy of this decision to the State home facility and to the State official authorized to oversee the operations of the State home.

(g) In the event that a VA survey team or other VA medical center staff identifies any condition that poses an immediate threat to public or patient safety or other information indicating the existence of such a threat, the director of VA medical center of jurisdiction will immediately report this to the VA Network Director (10N 1-22), Chief Network Officer (10N), Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) and State official authorized to oversee operations of the State home. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

§51.31 Automatic recognition.

Notwithstanding other provisions of this part, a facility that already is recognized by VA as a State home for nursing home care at the time this part becomes effective, automatically will continue to be recognized as a State home for nursing home care but will be subject to all of the provisions of this part that apply to facilities that have achieved recognition, including the provisions requiring that the facility meet the standards set forth in subpart D and the provisions for withholding per diem payments and withdrawal of recognition.

Next Section is §51.40

Subpart C—Per Diem Payments

§51.40 Basic per diem.

Except as provided in §51.41 of this part,

(a) During Fiscal Year 2008 VA will pay a facility recognized as a State home for nursing home care the lesser of the following for nursing home care provided to an eligible veteran in such facility:

(1) One-half of the cost of the care for each day the veteran is in the facility; or

(2) $71.42 for each day the veteran is in the facility.

(b) During Fiscal Year 2009 and during each subsequent Fiscal Year, VA will pay a facility recognized as a State home for nursing home care the lesser of the following for nursing home care provided to an eligible veteran in such facility:

(1) One-half of the cost of the care for each day the veteran is in the facility; or

(2) The basic per diem rate for the Fiscal Year established by VA in accordance with 38 U.S.C. 1741(c). (Authority: 38 U.S.C. 101, 501, 1710, 1741-1744)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

§51.41 Per diem for certain veterans based on service-connected disabilities.

(a) VA will pay a facility recognized as a State home for nursing home care at the per diem rate determined under paragraph (b) of this section for nursing home care provided to an eligible veteran in such facility, if the veteran:

(1) Is in need of nursing home care for a VA adjudicated service-connected disability, or

(2) Has a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care.

(b) For purposes of paragraph (a) of this section, the rate is the lesser of the amount calculated under the paragraph (b)(1) or (b)(2) of this section.

(1) The amount determined by the following formula. Calculate the daily rate for the CMS RUG III (resource utilization groups version III) 53 case-mix levels for the applicable metropolitan statistical area if the facility is in a metropolitan statistical area, and calculate the daily rate for the CMS Skilled Nursing Prospective Payment System 53 case-mix levels for the applicable rural area if the facility is in a rural area. For each of the 53 case-mix levels, the daily rate for each State home will be determined by multiplying the labor component by the nursing home wage index and then adding to such amount the non-labor component and an amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, and then with the modified rate multiplied by 12 and then divided by the number of days in the year.

Note to paragraph (b)(1): The amount calculated under this formula reflects the applicable or prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing these rates includes CMS information that is published in the *Federal Register* every summer and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.

(2) A rate not to exceed the daily cost of care for the month in the State home facility, as determined by the Chief Consultant, Office of Geriatrics and Extended Care, following a report to the Chief Consultant, Office of Geriatrics and Extended Care under the provisions of §51.43(b) of this part by the director of the State home.

(c) Payment under this section to a State home for nursing home care provided to a veteran constitutes payment in full to the State home by VA for such care furnished to that veteran. Also, as a condition of receiving payments under this section, the State home must agree not to accept drugs and medicines from VA on behalf of veterans provided under 38 U.S.C. 1712(d) and corresponding VA regulations (payment under this section includes payment for drugs and medicines). (Authority: 38 U.S.C. 101, 501, 1710, 1741-1744)

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

[74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

§51.42 Drugs and medicines for certain veterans.

(a) In addition to per diem payments under §51.40 of this part, the Secretary shall furnish drugs and medicines to a facility recognized as a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving care in a State home, if:

(1) The veteran:

(i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and is in need of such drugs and medicines for a service-connected disability; and

(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability, or

(2) The veteran:

(i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and is in need of such drugs and medicines; and

(ii) Is in need of nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.

(b) VA may furnish a drug or medicine under paragraph (a) of this section only if the drug or medicine is included on VA's National Formulary, unless VA determines a non-Formulary drug or medicine is medically necessary.

(c) VA may furnish a drug or medicine under paragraph (a) of this section by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means determined by VA. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1744)

[74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

§51.43 Per diem and drugs and medicines–principles.

(a) As a condition for receiving payment of per diem under this part, the State home must submit to the VA medical center of jurisdiction for each veteran a completed VA Form 10-10EZ, Application for Medical Benefits (or VA Form 10-10EZR, Health Benefits Renewal Form, if a completed Form 10-10EZ is already on file at VA), and a completed VA Form 10-10SH, State Home Program Application for Care–Medical Certification. These VA Forms must be submitted at the time of admission and with any request for a change in the level of care (domiciliary, hospital care or adult day health care). In case the level of care has changed or contact information is outdated, VA Forms 10-10EZ and 10-10EZR are set forth in full at §58.12 and VA Form 10-10SH is set forth in full at §58.13. If the facility is eligible to receive per diem payments for a veteran, VA will pay per diem under this part from the date of receipt of the completed forms required by this paragraph, except that VA will pay per diem from the day on which the veteran was admitted to the facility if the completed forms are received within 10 days after admission.

(b) VA pays per diem on a monthly basis. To receive payment, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-5588, State Home Report and Statement of Federal Aid Claimed. This form is set forth in full at §58.11 of this chapter.

(c) Per diem will be paid under §§51.40 and 51.41 for each day that the veteran is receiving care and has an overnight stay. Per diem also will be paid when there is no overnight stay if the veteran has resided in the facility for 30 consecutive days (including overnight stays) and the facility has an occupancy rate of 90 percent or greater. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care.

(d) Initial per diem payments will not be made until the Under Secretary for Health recognizes the State home. However, per diem payments will be made retroactively for care that was provided on and after the date of the completion of the VA survey of the facility that provided the basis for determining that the facility met the standards of this part.

(e) The daily cost of care for an eligible veteran's nursing home care for purposes of §§51.40(a)(1) and 51.41(b)(2) consists of those direct and indirect costs attributable to nursing home care at the facility divided by the total number of residents at the nursing home. Relevant cost principles are set forth in the Office of Management and Budget (OMB) Circular number A-87, dated May 4, 1995, "Cost Principles for State, Local, and Indian Tribal Governments."

(f) As a condition for receiving drugs and medicines under this part, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 for each eligible veteran. This form is set forth in full at §58.18 of this chapter. The corresponding prescriptions described in §51.42 also should be submitted to the VA medical center of jurisdiction. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1744)

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0091 and 2900-0160.)

[74 FR 19432, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.50

§51.50 Eligible veterans.

A veteran is an eligible veteran under this part if VA determines that the veteran needs nursing home care and the veteran is within one of the following categories:

(a) Veterans with service-connected disabilities;

(b) Veterans who are former prisoners of war;

(c) Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty;

(d) Veterans who receive disability compensation under 38 U.S.C. 1151;

(e) Veterans whose entitlement to disability compensation is suspended because of the receipt of retired pay;

(f) Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for nursing home care is provided for in the judgment or settlement described in 38 U.S.C. 1151;

(g) Veterans who VA determines are unable to defray the expenses of necessary care as specified under 38 U.S.C. 1722(a);

(h) Veterans of the Mexican border period or of World War I;

(i) Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation or for a disorder associated with service in the Southwest Asia theater of operations during the Persian Gulf War, as provided in 38 U.S.C. 1710(e);

(j) Veterans who agree to pay to the United States the applicable co-payment determined under 38 U.S.C. 1710(f) and 1710(g). (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

Next Section is §51.60

Subpart D—Standards

§51.60 Standards applicable for payment of per diem.

The provisions of this subpart are the standards that a State home and facility management must meet for the State to receive per diem for nursing home care.

Next Section is §51.70

§51.70 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights:

(a) *Exercise of rights.*

(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights.

(3) The resident has the right to freedom from chemical or physical restraint.

(4) In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(5) In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

(b) *Notice of rights and services.*

(1) The facility management must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and periodically during the resident's stay.

(2) The resident or his or her legal representative has the right:

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for review, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (b)(7) of this section; and

(5) The facility management must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services to be billed to the resident.

(6) The facility management must furnish a written description of legal rights which includes:

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A statement that the resident may file a complaint with the State (agency) concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(7) The facility management must have written policies and procedures regarding advance directives (e.g., living wills) that include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(8) The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care.

(9) *Notification of changes.*

(i) Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is:

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §51.80(a) of this part.

(ii) The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:

(A) A change in room or roommate assignment as specified in §51.100(f)(2); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member.

(c) *Protection of resident funds.*

(1) The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility.

(2) *Management of personal funds.* Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3) through (c)(6) of this section.

(3) *Deposit of funds.*

(i) *Funds in excess of $100.* The facility management must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) *Funds less than $100.* The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(4) *Accounting and records.* The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request from the resident or his or her legal representative.

(5) *Conveyance upon death.* Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows.

(6) *Assurance of financial security.* The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.

(d) *Free choice.* The resident has the right to:

(1) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(2) Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(e) *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident.

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident's right to refuse release of personal and clinical records does not apply when:

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

(f) *Grievances.* A resident has the right to:

(1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(g) *Examination of survey results.* A resident has the right to:

(1) Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(h) *Work.* The resident has the right to:

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when:

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care.

(i) *Mail.* The resident must have the right to privacy in written communications, including the right to:

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident's own expense.

(j) *Access and visitation rights.*

(1) The resident has the right and the facility management must provide immediate access to any resident by the following:

(i) Any representative of the Under Secretary for Health;

(ii) Any representative of the State;

(iii) Physicians of the resident's choice (to provide care in the nursing home, physicians must meet the provisions of §51.210(j));

(iv) The State long term care ombudsman;

(v) Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and

(vi) Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time.

(2) The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law.

(k) *Telephone.* The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.

(l) *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(m) *Married couples.* The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(n) *Self-Administration of Drugs.* An individual resident may self-administer drugs if the interdisciplinary team, as defined by §51.110(d)(2)(ii) of this part, has determined that this practice is safe. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

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Supplement *Highlights* reference: 47(1)

Next Section is §51.80

§51.80 Admission, transfer and discharge rights.

(a) *Transfer and discharge.*

(1) *Definition*: *Transfer and discharge* includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility.

(2) *Transfer and discharge requirements*. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or

(vi) The nursing home ceases to operate.

(3) *Documentation*. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document this in the resident's clinical record.

(4) *Notice before transfer*. Before a facility transfers or discharges a resident, the facility must:

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) *Timing of the notice*.

(i) The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(5)(ii) of this section,

(ii) Notice may be made as soon as practicable before transfer or discharge when:

(A) The safety of individuals in the facility would be endangered;

(B) The health of individuals in the facility would be otherwise endangered;

(C) The resident's health improves sufficiently so the resident no longer needs the services provided by the nursing home;

(D) The resident's needs cannot be met in the nursing home;

(6) *Contents of the notice*. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State official designated by the State; and

(v) The name, address and telephone number of the State long term care ombudsman.

(7) *Orientation for transfer or discharge*. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(b) *Notice of bed-hold policy and readmission.*

(1) *Notice before transfer*. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies:

(i) The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and

(ii) The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) *Bed-hold notice upon transfer*. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) *Permitting resident to return to facility*. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room, if the resident requires the services provided by the facility.

(c) *Equal access to quality care*. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.

(d) *Admissions policy*. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay

in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract to pay the facility from the resident's income or resources. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.90

§51.90 Resident behavior and facility practices.

(a) *Restraints.*

(1) The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention.

(i) Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior.

(ii) Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints.

(2) The facility management uses a system to achieve a restraint-free environment.

(3) The facility management collects data about the use of restraints.

(4) When alternatives to the use of restraint are ineffective, a restraint must be safely and appropriately used.

(b) *Abuse*. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion.

(1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation.

(2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment.

(3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault.

(4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions.

(5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.

(c) *Staff treatment of residents*. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility management must:

(i) Not employ individuals who:

(A) Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or

(B) Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and

(ii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.

(3) The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within 5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, June 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.100

§51.100 Quality of life.

A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) *Dignity.* The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) *Self-determination and participation.* The resident has the right to:

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(c) *Resident Council.* The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.

(d) *Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility;

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility;

(3) The facility management must provide the council and any resident or family group that exists with private space;

(4) Staff or visitors may attend meetings at the group's invitation;

(5) The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;

(6) The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility.

(e) *Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the

facility. The facility management must arrange for religious counseling by clergy of various faith groups.

(f) *Accommodation of needs.* A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(2) Receive notice before the resident's room or roommate in the facility is changed.

(g) *Patient Activities.*

(1) The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is licensed or registered, if applicable, by the State in which practicing; and

(ii) Is certified as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body.

(h) *Social Services.*

(1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident.

(2) For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE).

(3) *Qualifications of social worker.* A qualified social worker is an individual with:

(i) A bachelor's degree in social work from a school accredited by the Council of Social Work Education (Note: A master's degree social worker with experience in long-term care is preferred), and

(ii) A social work license from the State in which the State home is located, if offered by the State, and

(iii) A minimum of one year of supervised social work experience in a health care setting working directly with individuals.

(4) The facility management must have sufficient support staff to meet patients' social services needs.

(5) Facilities for social services must ensure privacy for interviews.

(i) *Environment*. The facility management must provide:

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Clean bed and bath linens that are in good condition;

(4) Private closet space in each resident room, as specified in §51.200(d)(2)(iv) of this part;

(5) Adequate and comfortable lighting levels in all areas;

(6) Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees Fahrenheit; and

(7) For the maintenance of comfortable sound levels. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.110

§51.110 Resident assessment.

The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders*. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.

(b) *Comprehensive assessments*.

(1) The facility management must make a comprehensive assessment of a resident's needs:

(i) Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0; and

(ii) Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity.

(2) *Frequency*. Assessments must be conducted:

(i) No later than 14 days after the date of admission;

(ii) Promptly after a significant change in the resident's physical, mental, or social condition; and

(iii) In no case less often than once every 12 months.

(3) *Review of assessments*. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(4) *Use*. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.

(c) *Accuracy of assessments*.

(1) *Coordination*:

(i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.

(2) *Certification.* Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Submission of assessments.* Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document.

(e) *Comprehensive care plans.*

(1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and

(ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part.

(2) A comprehensive care plan must be:

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must:

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(f) *Discharge summary*. Prior to discharging a resident, the facility management must prepare a discharge summary that includes:

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.120

§51.120 Quality of care.

Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of Sentinel Events.*

(1) *Definition.* A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or

(iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or

(vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) within 24 hours of notification.

(4) The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Talk or otherwise communicate.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.

(c) *Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident:

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(d) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(e) *Urinary and Fecal Incontinence.* Based on the resident's comprehensive assessment, the facility management must ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(2) A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible; and

(3) A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.

(f) *Range of motion.* Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(g) *Mental and Psychosocial functioning*. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.

(h) *Enteral Feedings*. Based on the comprehensive assessment of a resident, the facility management must ensure that:

(1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and

(2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.

(i) *Accidents*. The facility management must ensure that:

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(j) *Nutrition*. Based on a resident's comprehensive assessment, the facility management must ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when a nutritional deficiency is identified.

(k) *Hydration*. The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(l) *Special needs*. The facility management must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(m) *Unnecessary drugs*.

(1) *General*. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) *Antipsychotic Drugs*. Based on a comprehensive assessment of a resident, the facility management must ensure that:

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(n) *Medication Errors*. The facility management must ensure that:

(1) Medication errors are identified and reviewed on a timely basis; and

(2) strategies for preventing medication errors and adverse reactions are implemented. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.130

§51.130 Nursing services.

The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week.

(a) The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.

(b) The facility management must provide registered nurses 24 hours per day, 7 days per week.

(c) The director of nursing service must designate a registered nurse as a supervising nurse for each tour of duty.

(1) Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.

(2) Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.

(d) The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care.

(e) Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.140

§51.140 Dietary services.

The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(a) *Staffing*. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a dietitian is not employed, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.

(b) *Sufficient staff*. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) *Menus and nutritional adequacy*. Menus must:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(d) *Food*. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food that is palatable, attractive, and at the proper temperature;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) *Therapeutic diets*. Therapeutic diets must be prescribed by the primary care physician.

(f) *Frequency of meals*.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and the availability of breakfast the following day, except as provided in (f)(4) of this section.

(3) The facility staff must offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day.

(g) *Assistive devices*. The facility management must provide special eating equipment and utensils for residents who need them.

(h) *Sanitary conditions*. The facility must:

(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;

(2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

Next Section is §51.150

§51.150 Physician services.

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(a) *Physician supervision.* The facility management must ensure that:

(1) The medical care of each resident is supervised by a primary care physician;

(2) Each resident's medical record lists the name of the resident's primary physician, and

(3) Another physician supervises the medical care of residents when their primary physician is unavailable.

(b) *Physician visits.* The physician must:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders.

(c) *Frequency of physician visits.*

(1) The resident must be seen by the primary physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or more frequently based on the condition of the resident.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(3) Except as provided in paragraphs (c)(4) of this section, all required physician visits must be made by the physician personally.

(4) At the option of the physician, required visits in the facility after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(d) *Availability of physicians for emergency care.* The facility management must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency.

(e) *Physician delegation of tasks.*

(1) Except as specified in paragraph (e)(2) of this section, a primary physician may delegate tasks to:

(i) a certified physician assistant or a certified nurse practitioner, or

(ii) a clinical nurse specialist who:

(A) Is acting within the scope of practice as defined by State law; and

(B) Is under the supervision of the physician.

Note to paragraph (e): An individual with experience in long term care is preferred.

(2) The primary physician may not delegate a task when the regulations specify that the primary physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.160

§51.160 Specialized rehabilitative services.

(a) *Provision of services*. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must:

(1) Provide the required services; or

(2) Obtain the required services from an outside resource, in accordance with §51.210(h) of this part, from a provider of specialized rehabilitative services.

(b) Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.170

§51.170 Dental services.

(a) A facility must provide or obtain from an outside resource, in accordance with §51.210(h) of this part, routine and emergency dental services to meet the needs of each resident;

(b) A facility may charge a resident an additional amount for routine and emergency dental services; and

(c) A facility must, if necessary, assist the resident:

(1) In making appointments;

(2) By arranging for transportation to and from the dental services; and

(3) Promptly refer residents with lost or damaged dentures to a dentist. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

Next Section is §51.180

§51.180 Pharmacy services.

The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §51.210(h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff.

(a) *Procedures.* The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) *Service consultation.* The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located or a VA pharmacist under VA contract who:

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) *Drug regimen review.*

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.

(d) *Labeling of drugs and biologicals.* Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(e) *Storage of drugs and biologicals.*

(1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.190

§51.190 Infection control.

The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) *Infection control program.* The facility management must establish an infection control program under which it:

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) *Preventing spread of infection.*

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.

(2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease.

(3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) *Linens.* Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

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

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Next Section is §51.200

§51.200 Physical environment.

The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) *Life safety from fire*. The facility must meet the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition), except that the requirement in paragraph 19.3.5.1 for all buildings containing nursing homes to have an automatic sprinkler system is not applicable until August 13, 2013, unless an automatic sprinkler system was previously required by the Life Safety Code and the NFPA 99, Standard for Health Care Facilities (2005 edition). Incorporation by reference of these materials was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials incorporated by reference are available for inspection at the Office of the Federal Register, Suite 700, 800 North Capitol Street, NW., Washington, DC, and the Department of Veterans Affairs, Office of Regulation Policy and Management (02REG), 810 Vermont Avenue, NW., Washington, DC 20420. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, MA 02269-9101. (For ordering information, call toll-free 1/800-344-3555.)

(b) *Emergency power*.

(1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.

(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition). Incorporation by reference of these materials was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. The availability of these materials is described in paragraph (a) of this section.

(3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Standard for Health Care Facilities (2005 edition).

(4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition). Incorporation by reference of these materials was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. The availability of these materials is described in paragraph (a) of this section.

(c) *Space and equipment*. Facility management must:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(d) *Resident rooms*. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents:

(1) Bedrooms must:

(i) Accommodate no more than four residents;

(ii) Measure at least 115 net square feet per resident in multiple resident bedrooms;

(iii) Measure at least 150 net square feet in single resident bedrooms;

(iv) Measure at least 245 net square feet in small double resident bedrooms; and

(v) Measure at least 305 net square feet in large double resident bedrooms used for spinal cord injury residents. It is recommended that the facility have one large double resident bedroom for every 30 resident bedrooms.

(vi) Have direct access to an exit corridor;

(vii) Be designed or equipped to assure full visual privacy for each resident;

(viii) Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(ix) Have at least one window to the outside; and

(x) Have a floor at or above grade level.

(2) The facility management must provide each resident with:

(i) A separate bed of proper size and height for the safety of the resident;

(ii) A clean, comfortable mattress;

(iii) Bedding appropriate to the weather and climate; and

(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(e) *Toilet facilities*. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas.

(f) *Resident call system*. The nurse's station must be equipped to receive resident calls through a communication system from:

(1) Resident rooms; and

(2) Toilet and bathing facilities.

(g) *Dining and resident activities*. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must:

(1) Be well lighted;

(2) Be well ventilated;

(3) Be adequately furnished; and

(4) Have sufficient space to accommodate all activities.

(h) *Other environmental conditions*. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must:

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

(3) Equip corridors with firmly secured handrails on each side; and

(4) Maintain an effective pest control program so that the facility is free of pests and rodents. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Next Section is §51.210

§51.210 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.

(a) *Governing body.*

(1) The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(2) The governing body or State official with oversight for the facility appoints the administrator who is:

(i) Licensed by the State where licensing is required; and

(ii) Responsible for operation and management of the facility.

(b) *Disclosure of State agency and individual responsible for oversight of facility.* The State must give written notice to the Chief Consultant, Office of Geriatrics and Extended Care (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change:

(1) The State agency and individual responsible for oversight of a State home facility;

(2) The State home administrator; and

(3) The State employee responsible for oversight of the State home facility if a contractor operates the State home.

(c) *Required Information.* The facility management must submit the following to the director of the VA medical center of jurisdiction as part of the application for recognition and thereafter as often as necessary to be current or as specified:

(1) The copy of legal and administrative action establishing the State-operated facility (e.g., State laws);

(2) Site plan of facility and surroundings;

(3) Legal title, lease, or other document establishing right to occupy facility;

(4) Organizational charts and the operational plan of the facility;

(5) The number of the staff by category indicating full-time, part-time and minority designation (annual at time of survey);

(6) The number of nursing home patients who are veterans and non-veterans, the number of veterans who are minorities and the number of non-veterans who are minorities (annual at time of survey);

(7) Annual State Fire Marshall's report;

(8) Annual certification from the responsible State Agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A set forth at §58.14 of this chapter);

(9) Annual certification for Drug-Free Workplace Act of 1988 (VA Form 10-0143 set forth at §58.15 of this chapter);

(10) Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144 set forth at §58.16 of this chapter); and

(11) Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 10-0144A located at §58.17 of this chapter).

(d) *Percentage of Veterans*. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veteran residents must be spouses of veterans or parents all of whose children died while serving in the armed forces of the United States.

(e) *Management Contract Facility*. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.

(f) *Licensure*. The facility and facility management must comply with applicable State and local licensure laws.

(g) *Staff qualifications*.

(1) The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

(h) *Use of outside resources*.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section.

(2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for:

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

(i) *Medical director*.

(1) The facility management must designate a primary care physician to serve as medical director.

(2) The medical director is responsible for:

(i) Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services;

(ii) Directing and coordinating medical care in the facility;

(iii) Helping to arrange for continuous physician coverage to handle medical emergencies;

(iv) Reviewing the credentialing and privileging process;

(v) Participating in managing the environment by reviewing and evaluating incident reports or summaries of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and

(vi) Monitoring employees' health status and advising the administrator on employee-health policies.

(j) *Credentialing and Privileging*. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance.

(1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care.

(2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide.

(3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied.

(4) The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility.

(5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience.

(6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted.

(k) *Required training of nursing aides.*

(1) *Nurse aide* means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay.

(2) The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless:

(i) That individual is competent to provide nursing and nursing related services; and

(ii) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.

(3) *Registry verification.* Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(4) *Multi-State registry verification.* Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.

(5) *Required retraining.* If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(6) *Regular in-service education.* The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must:

(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;

(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(l) *Proficiency of Nurse aides.* The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(m) *Level B Requirement Laboratory services.*

(1) The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services.

(ii) If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes, and regulations.

(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialities and subspecialties of services and meet certification standards, statutes, and regulations.

(iv) The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection.

(v) Such services must be available to the resident seven days a week, 24 hours a day.

(2) The facility management must:

(i) Provide or obtain laboratory services only when ordered by the primary physician;

(ii) Promptly notify the primary physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(n) *Radiology and other diagnostic services.*

(1) The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations.

(iii) Radiologic and other diagnostic services must be available 24 hours a day, seven days a week.

(2) The facility must:

(i) Provide or obtain radiology and other diagnostic services when ordered by the primary physician;

(ii) Promptly notify the primary physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

(o) *Clinical records.*

(1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(2) Clinical records must be retained for:

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law.

(3) The facility management must safeguard clinical record information against loss, destruction, or unauthorized use;

(4) The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract;

(iv) The resident or;

(v) The resident's authorized agent or representative.

(5) The clinical record must contain:

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The plan of care and services provided;

(iv) The results of any pre-admission screening conducted by the State; and

(v) Progress notes.

(p) *Quality assessment and assurance.*

(1) Facility management must maintain a quality assessment and assurance committee consisting of:

(i) The director of nursing services;

(ii) A primary physician designated by the facility; and

(iii) At least 3 other members of the facility's staff.

(2) The quality assessment and assurance committee:

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies; and

(3) Identified quality deficiencies are corrected within an established time period.

(4) The VA Under Secretary for Health may not require disclosure of the records of such committee unless such disclosure is related to the compliance with requirements of this section.

(q) *Disaster and emergency preparedness.*

(1) The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

(r) *Transfer agreement.*

(1) The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that:

(i) Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and

(ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(s) *Compliance with Federal, State, and local laws and professional standards.* The facility management must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This includes the Single Audit Act of 1984 (Title 31, Section 7501, *et seq.*) and the Cash Management Improvement Acts of 1990 and 1992 (Public Laws 101-453 and 102-589, see 31 USC 3335, 3718, 3720A, 6501, 6503)

(t) *Relationship to other Federal regulations.* In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other Federal laws and regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, or age (38 CFR part 18); protection of human subjects of research (45 CFR part 46), section 504 of the Rehabilitation Act of 1993, Public Law 93-112; Drug-Free Workplace Act of 1988, 38 CFR part 48; section 319 of Public Law 101-121; Title VI of the Civil Rights Act of 1964, 38 CFR 18.1-18.3. Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(u) *Intermingling.* A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.

(v) *VA Management of State Veterans Homes.* Except as specifically provided by statute or regulations, VA employees have no authority regarding the management or control of State homes providing nursing home care. (Authority: 38 U.S.C. 101, 501, 1710, 1741-1743, 8135)

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

[65 FR 968, Jan. 6, 2000, as amended at 72 FR 30243, May 31, 2007; 74 FR 19432, 19434, Apr. 29, 2009]

Supplement *Highlights* references: 38(1), 47(1)

End of Part 51

Reserved

58.INDEX-1

Part 58

Forms

Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

Source: 65 Fed. Reg. 981, January 6, 2000, unless otherwise indicated.

— Form Number Index —

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58.INDEX-2

Part 58

Forms

Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

Source: 65 Fed. Reg. 981, January 6, 2000, unless otherwise indicated.

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

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

Department of Veterans Affairs

STATE HOME INSPECTION

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

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

(Original 1/25/00)

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

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

Department of Veterans Affairs

INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

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

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

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

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

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

2. GENERAL INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) Line 12, Female Veteran Residents Remaining at the end of the month.

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CONTINUED INSTRUCTIONS FOR STATE HOME REPORT AND STATEMENT OF FEDERAL AID

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

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

3. INSTRUCTIONS FOR MONTHLY SUMMARY STATEMENT ACCOUNT.

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

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

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

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

e. Column I, Total Amount Claimed.

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

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

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

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

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

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

5. OPERATING BEDS

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

6. CERTIFICATION

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

b. If the facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time, on site basis. This State employee must also certify that the information in the report is correct by signing and dating the report.

VA FORM JUL 2008 **10-5588**

Department of Veterans Affairs

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED

TO	VA FACILITY	FROM	NAME AND ADDRESS OF STATE HOME
PAY TO			FOR MONTH ENDING

CHANGES IN RESIDENCY FOR THE MONTH

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

STATUS AS OF THE END OF THE MONTH

LINE NO.	ITEM	DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
10	TOTAL NON-VETERAN RESIDENTS AT THE END OF THE MONTH				
11	TOTAL NURSING HOME CARE VETS THAT ARE 70% OR MORE SC OR IN NEED OF NH CARE FOR A SC CONDITION				
12	FEMALE VETERAN RESIDENTS REMAINING AT THE END OF THE MONTH				

TOTAL DAYS OF CARE FOR THE MONTH

LINE NO.	ITEM	DOMICILIARY (A)	NURSING HOME CARE (B)	HOSPITAL (C)	ADULT DAY HEALTH CARE (D)
13	TOTAL DAYS OF CARE FURNISHED TO VETERANS WHO ARE ELIGIBLE FOR PER DIEM PAYMENTS *(Excluding 13a)*				
13a	TOTAL DAYS OF CARE FURNISHED TO VETERANS 70% OR MORE SC OR IN NEED OF CARE FOR A SC CONDITION				

VA FORM JUL 2008 **10-5588**

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

CLAIM FOR BASIC PER DIEM PAYMENTS FOR ELIGIBLE VETERANS

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

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

LINE NO.	VETERAN CATEGORY	DAYS OF CARE (J)	AVERAGE DAILY CENSUS (K)	PREVAILING RATE FROM CHART OR (G) 15 WHICHEVER IS LESS (L)	AMOUNT CLAIMED (M)
19	HAS A SINGULAR OR COMBINED RATING OF 70% OR MORE BASED ON 1 OR MORE SERVICE-CONNECTED DISABILITIES OR A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY				
20	IS IN NEED OF NH CARE FOR A VA ADJUDICATED SC DISABILITY				
21	TOTALS:				

FOR UNITED STATES DEPARTMENT OF VETERANS AFFAIRS USE ONLY

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

BED CAPACITY APPROVED BY VA

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

RECEIVING REPORT

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

TOTAL AMOUNT APPROVED BY VA FOR PAYMENT (add block 18i and 21M)

SIGNATURE AND TITLE OF VA STATE HOME COORDINATOR | DATE

ACCOUNTING CERTIFICATION - AUDIT BLOCK

AMOUNT DUE	DATE	VOUCHER AUDITOR

SIGNATURE AND TITLE OF AUDITOR | DATE

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

VA FORM JUL 2008 **10-5588**

STATE HOME REPORT AND STATEMENT OF FEDERAL AID CLAIMED CONTINUED

TOTAL STATE OPERATING BEDS AT END OF THE MONTH

DOMICILIARY CARE	NURSING HOME CARE	HOSPITAL CARE	ADULT DAY HEALTH CARE

I certify that this report is correct, that all residents included in the report were physically present during the period for which Federal aid is claimed, except for authorized absences of 96 hours or less, and that facility management has complied with all provisions of Title VI, Public Law 88-352, entitled Civil Rights Act of 1964.

SIGNATURE OF STATE HOME ADMINISTRATOR	DATE

SIGNATURE OF STATE EMPLOYEE WHEN APPLICABLE	DATE

REMARKS

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. Although completion of this form is voluntary, VA will be unable to provide reimbursement for services rendered without a completed form. Failure to complete the form will have no effect on any other benefits to which you may be entitled. This information is collected under the authority of Title 38 CFR Parts 51 and 52.

VA FORM 10-5588
JUL 2008

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

§58.12 VA Forms 10-10EZ and 10-10EZR—Application for Health Benefits and Renewal Form

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

Department of Veterans Affairs — **APPLICATION FOR HEALTH BENEFITS**

SECTION I - GENERAL INFORMATION

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

1. VETERAN'S NAME *(Last, First, Middle Name)*	2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH *(mm/dd/yyyy)*	10. RELIGION
8. CLAIM NUMBER	9A. PLACE OF BIRTH *(City and State)*	

11. PERMANENT ADDRESS *(Street)*	11A. CITY	11B. STATE	11C. ZIP CODE *(9 digits)*
11D. COUNTY	11E. HOME TELEPHONE NUMBER *(Include area code)*	11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER *(Include area code)*	11H. PAGER NUMBER *(Include area code)*		

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

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?

14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.	15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? ☐ YES, LOCATION: ☐ NO

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

17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	17A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
	17B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
	18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

VA FORM JUL 2008 **10-10EZ** *PREVIOUS EDITIONS OF THIS FORM ARE NOT TO BE USED* PAGE 1

APPLICATION FOR HEALTH BENEFITS, Continued

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

SECTION II - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO		2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
3. NAME OF POLICY HOLDER			
4. POLICY NUMBER	5. GROUP CODE		
	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO			12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED *If employed or retired, complete item 1A* ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED *If employed or retired, complete item 2A* ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

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

☐ **No, I do not wish to provide financial information in Sections VII through X.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have a special eligibility factor (e.g., recently discharged combat veteran, compensable service connection, receipt of VA pension or Medicaid benefits.) If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XII.*

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

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

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE: $ CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

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

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(eg., Social Security, compensation, pension interest, dividends)*, EXCLUDING WELFARE	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VII.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

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

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

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

SIGNATURE OF APPLICANT	DATE

OMB Approved No. 2900-0091
Estimated Burden Avg. 24 min.

Department of Veterans Affairs

HEALTH BENEFITS RENEWAL FORM

SECTION I - GENERAL INFORMATION

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

1. VETERAN'S NAME *(Last, First, Middle Name)*
2. OTHER NAMES USED
3. GENDER ☐ MALE ☐ FEMALE
4. SOCIAL SECURITY NUMBER
5. DATE OF BIRTH *(mm/dd/yyyy)*
6. PERMANENT ADDRESS *(Street)*
6A. CITY
6B. STATE
6C. ZIP
6D. COUNTY
6E. HOME TELEPHONE NUMBER *(Include area code)*
6F. E-MAIL ADDRESS
6G. CELLULAR TELEPHONE NUMBER *(Include area code)*
6H. PAGER NUMBER *(Include area code)*
7. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN
8. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN
8A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
8B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
9. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT
9A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
9B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*
10. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. Note: This does not constitute a will or transfer of title. *(Check one)* ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE, INCLUDING COVERAGE THROUGH A SPOUSE OR ANOTHER PERSON? ☐ YES ☐ NO
2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER
4. POLICY NUMBER
5. GROUP CODE
6. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO
7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? ☐ YES ☐ NO
8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD
10. MEDICARE CLAIM NUMBER

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(check one)* ☐ FULL TIME ☐ NOT EMPLOYED
If employed or retired, complete item 1A ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*
1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(check one)* ☐ FULL TIME ☐ NOT EMPLOYED
If employed or retired, complete item 2A ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*
2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 24 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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

VA FORM JUL 2008 **10-10EZR** *Previous editions of this form are not to be used.* PAGE 1

Department of Veterans Affairs

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

SECTION V - FINANCIAL DISCLOSURE

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

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

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

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

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
	2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

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

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(eg., wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS.	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS.	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)*. EXCLUDING WELFARE	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE LAST CALENDAR YEAR *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)* VA will calculate a deductible and the net medical expenses you may claim.	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials)* DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	$

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

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds.)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property.)* DO NOT INCLUDE YOUR PRIMARY HOME.	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION X - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copays for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copays as required by law.**

SECTION XI - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

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

SIGNATURE OF APPLICANT	DATE *(mm/dd/yyyy)*

VA FORM JUL 2008 **10-10EZR** PAGE 2

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19439, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

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

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

Department of Veterans Affairs

STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER ☐ M ☐ F
RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	SOCIAL SECURITY NUMBER. *(Mandatory field)*	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH *(mm/dd/yyyy)*
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES	

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

HISTORY

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

NECK	CARDIOPULMONARY
ABDOMEN	GENITOURINARY
RECTAL	EXTREMITIES
NEUROLOGICAL	ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB	CHEST X-RAY	DATE *(mm/dd/yyyy)*	RESULTS	CBC	DATE *(mm/dd/yyyy)*	RESULTS
	SEROLOGY					
	URINALYSIS	DATE *(mm/dd/yyyy)*	ALBUMEN	SUGAR		ACETONE

CHECK ALL BOXES THAT APPLY OR CHECK NA ☐

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

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

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

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

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

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

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

VA FORM APR 2009 **10-10SH** EXISTING STOCK OF VA FORM 10-10SH, DATED JUL 1998, WILL BE USED. PAGE 1

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

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

EVALUATION (Select an appropriate number in each category)

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

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN | DATE

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

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

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

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

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

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

VA AUTHORIZATION FOR PAYMENT

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT APPROVED DISAPPROVED	LEVEL OF CARE RECOMMENDED NHC DOMICILIARY HOSPITAL ADHC
APPROVED FOR 70% SERVICE CONNECTED DISABILITY YES NO	APPROVED FOR ADMITANCE BECAUSE OF SERVICE CONNECTED ILLNESS (IF LESS THAN 70%) ILLNESS:	
SIGNATURE OF VA OFFICIAL / DATE	SIGNATURE OF VA PHYSICIAN / DATE	

VA FORM APR 2009 **10-10SH** **PAGE 2**

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742 and 1743. It is being collected to enable us to determine your eligibility for medical benefits in the State Home Program and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

VA FORM
APR 2009 **10-10SH**

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19444, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

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

OMB Number: 2900-0160
Estimated Burden: 5 minutes

Department of Veterans Affairs

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

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

_____ (hereinafter called the "Signatory")

(Name and location of State Veterans Home)

HEREBY AGREES THAT

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

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

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

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

SIGNATURE OF AUTHORIZED OFFICIAL	
TITLE	DATE
MAILING ADDRESS	

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

(Original 1/25/00)

§58.18 VA Form 10-0460—Request for Prescription Drugs from an Eligible Veteran in a State Home

OMB Approval No. 2900-XXXX
Estimated Burden: 30 minutes

Department of Veterans Affairs — **Request for Prescription Drugs from an Eligible Veteran in a State Home**

	VA Facility		**Name and Address of State Home**
To:		**From:**	

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

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

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

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

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

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

Signature of Veteran Applying for Benefit _____ **Date of Application** _____

Applicant Information

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

Veteran's Social Security Number:	**Date of Admission to the State Nursing Home:**

Date that A&A or Housebound was awarded by VA:

(a copy of this award ☐ is or ☐ is not attached with this request)

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Diagnosis/Diagnoses for which the Applicant was Admitted to the State Nursing Home		
Diagnosis Code	**Diagnosis Name**	**Category of Eligibility from page 1** *(1, 2, 3 or 4)*
Name of Prescribing Physician:		**Telephone Number:**

I certify that the following medications are prescribed for _____ .
Veteran's Name

_____
Signature of State Home Representative

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. We may not conduct or sponsor, and the respondent is not required to respond to, a collection unless it displays a valid OMB Control Number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, gather the necessary facts and fill out the form. This information is collected under the authority of Title 38 CFR Parts 51 and 58. It is being collected under the medical benefits in the State Homes Program and will be used for that purpose.

Privacy Act Information: It is being collected to enable us to determine your eligibility for medical benefits and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is mandatory. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute

VA FORM FEB 2008 **10-0460**

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[74 FR 19447, Apr. 29, 2009]

Supplement *Highlights* reference: 47(1)

Reserved