State of South Carolina Veterans Homes

APPLICATION FOR ADMISSION

State of South Carolina

State Veterans Homes

Thank you for your interest in our State Veterans Homes. We look forward to providing a pleasant and safe environment at one of our five locations for you and your loved one. Our standardized admissions process provides an easy and effective method for completing and submitting this application for placement at the State Veterans Home of your choice. Please complete the enclosed application and indicate your preference by selecting one of the locations listed below. The address and telephone number for each location is provided on page two of this packet. If you do not have a preference and would like to be placed in the first available opening, please select "First Available Opening" from the list below:

___ E. Roy Stone Jr. Veterans Home, Columbia SC

___ Richard M. Campbell Veterans Home, Anderson, SC

___ Veterans Victory House, Walterboro, SC

___ Palmetto Patriots Home, Gaffney, SC

___ Veteran Village, Florence, SC

___ First Available Opening

**All 5 of the State Veterans Homes are Tobacco-Free Campuses.*

Our admission application consists of the following:

- **Part 1**. Personal Admission Information – For the Veteran or Resident Representative
- **Part 2.** Medical Information – For the health care providers to complete

It is important that Parts 1 and 2 be thoroughly completed and signed.
****Please note that incomplete applications will not be processed****

In order for an application to be considered complete, the following must be also included:

- Copy of DD 214 and/or Honorable discharge paperwork
- Copies of Insurance cards
- Copies of Power of Attorney (if applicable)
- Current Photo (optional)
- Medication List from Healthcare Provider
- Physician History and Physical or Progress Notes
- Current Immunization Records

Once complete, please return Parts 1 and 2 as well as the items listed above by mail to the facility of your choice below:

E. Roy Stone Jr. Veterans Home:
Attention: Lashonda Mayfield RN, Admissions Coordinator
E. Roy Stone Veterans Pavilion
2200 Harden Street
Columbia, SC 29203

No appointment is necessary to drop off application. If you would like for us to review the application with you, please call Lashonda Mayfield, Admissions Coordinator at (803) 737-5411 to schedule an appointment.

If you would like to schedule an appointment for a tour, please call Lashonda Mayfield.

Richard M. Campbell Veterans Home:
Attention: Lydia Johnson, Admissions Assistant
Richard M. Campbell Veterans Home
4605 Belton Highway
Anderson, SC 29621

No appointment is necessary to drop off an application. If you would like for us to review the application with you, please call Lydia Johnson, Admissions Assistant at (864) 261-6734 to schedule an appointment.

If you would like to schedule an appointment for a tour, please call Lydia Johnson.

Veterans Victory House:
Attention: Stephanie Ballard, Director of Admissions
Veterans Victory House
2461 Sidneys Road
Walterboro, SC 29488

No appointment is necessary to drop off an application. However, if you would like for us to review the application with you, please call Stephanie Ballard, Director of Admissions at (843) 538-3000 ext. 102 or Amy Spears, RN, Admissions Coordinator at ext. 141 to schedule an appointment.

If you would like to schedule an appointment for a tour, please call Stephanie Ballard, Director of Admissions or Amy Spears, RN, Admissions Coordinator.

Palmetto Patriots Home:
Attention: Lydia Johnson, Admissions Assistant
120 Hampshire Drive
Gaffney, SC 29342

Be The First To Live In The Newest State Veteran Homes:
LJohnson@hmrvsi.com / 864-965-0373.

If you would like to schedule an appointment for a tour, please call Lydia Johnson.

Veteran Village:
Attention: Lydia Johnson, Admissions Assistant
1200 E. National Cemetery Road
Florence, SC 29506

Be The First To Live In The Newest State Veteran Homes:
LJohnson@hmrvsi.com / 864-965-0373.

If you would like to schedule an appointment for a tour, please call Lydia Johnson.

Admission Requirements:

- Veteran served active duty with an honorable discharge.
- Veteran has been a resident of South Carolina for the previous 12 months.
- Veteran meets Veterans Administration criteria for long term nursing care.

Process for Admission:

- The Admissions Coordinator will call to schedule an appointment for a home visit upon receipt of the Admission Packet. Please allow up to 2-3 weeks after the application has been submitted.
- Once the veteran is assessed and is accepted, he or she will be placed on a waiting list for an available bed.
  - Please begin preparation for admission at this time as we will not be able to give you an exact date for admission.
- Applications are kept on file for 12 months. Please be sure to keep a copy of your application.

Cost and Payment Information:

- The VA covers the majority of the total cost to include room and board, nursing, food, laundry services, haircuts, cable and basic personal items such as briefs and toiletries.
- The Veteran is responsible for the daily copay, as determined by the VA.
- The exception for this daily copay is a Veteran who has a 70% to 100% service-connected disability, for whom the VA pays the full cost.
- Our on-site pharmacy provides medications to all of our Veterans. Medications (that are on the VA formulary) are ONLY provided by the VA for residents who have Aide and Attendance or those who are 50% or higher service connected.
- The Veteran is responsible for ancillary charges such as, but not limited to, the physician copay, therapy, labs and medications. These charges are billed to the Veteran's insurance such as Medicare, Medicaid, Tricare, Medicare Part D or any other supplemental insurance coverage.

SOUTH CAROLINA STATE VETERANS HOMES

2414 Bull Street
Columbia, SC 29202
Reimbursement: (803) 898-8405

IMPORTANT NOTICE

Representative Payee:

- The South Carolina Department of Mental Health (SCDMH) will submit an application to become representative payee of Social Security, Veterans Administration, and other established benefit source(s) only if the resident for any reason is unable to act as his or her own payee benefits.
- An application for representative payee will also be submitted for any resident or responsible party if any billed balances are determined to be delinquent for 30 days or longer.

Setoff Debt:

- Any delinquent balances due on resident's account to SCDMH may be subject to collection under the Setoff Debt Collection Act, which is administered by the South Carolina Department of Revenue as authorized by statue.

Bed Hold:

- Per Facility bed hold policy, it will reserve the resident's bed at this published daily resident copayment rate, which applies if the resident has either a single medical leave occurrence from the facility of up to ten (10) consecutive days, or up to the first 12 days used per calendar year of all combined nonmedical leave occurrences from the facility.
- To continue to reserve the bed at the facility past the daily medical or on medical leave occurrence limitations listed above, the resident or his/her responsible party will be charged for the reserved bed at the full published daily rate.

If there are any questions, please contact SCDMH's Reimbursement Office at 803-898-8405 or at our main line at 803-898-0084.

(Notice Revised May 1, 2021)

PART 1
PERSONAL INFORMATION

SOUTH CAROLINA STATE VETERANS HOME ADMISSION CHECKLIST

This checklist must be returned with your application packet.

Veteran's Name: ____

Physical Location of Veteran: ______________________________________

Street: ____

City: ______________________ State: __________ Zip Code: ___________

Veteran Representative's Name: _____________________________________

Phone Number: ____________________ Email Address: ___________________

Admission Checklist

____ Personal Admission Information (2 pages)
____ State Citizenship (2nd page of Personal Admission Information Form)
____ Authorization for Release of Protected Health Information (SCDMH Form - 1 page)
____ 10-5345 Request for and Authorization to Release Medical Records of Health Information (Department of Veterans Affairs form - 1 page)
____ Authorization for Admission to a Department of Mental Health Nursing Home (SCDMH Form M-118 Page 1)
____ Advance Directives Information (SCDMH Form M-118 Page 2)
____ Proof of Honorable Discharge (DD214)
____ Insurance Cards
____ Power of Attorney, Living Will

The following forms MUST be obtained from and/or completed by the Veteran's Physician:

____ 10-10SH Department of Veterans Affairs Medical Certification (3 pages) (10-10SH MUST be signed by Physician/Medical Doctor ONLY)
____ SLUMS Examination (1 page) - VAMC Form - Nursing staff may complete and sign
____ PASARR - (2 pages) - Nursing staff may complete and sign
____ Tuberculin Skin Test (TST) within 30 days of admission AND prior TST within 12 months
____ If positive TST - must include Interpretable Chest X-Ray within 3 months of admissions date
____ History and Physical from Primary Care Physician/Nursing Home Physician
____ Current list of mediations from Primary Care Physician/MAR
____ Doctor's notes from the past 2-3 office visits
____ Immunization record to include FLU, Pneumonia Vaccines, and COVID-19 Vaccination.

Admission from Nursing Home: (If applicable)

____ Information as listed above
____ Most recent full MDS assessment, Care Plan, CAAS

SOUTH CAROLINA STATE VETERANS HOME

PERSONAL INFORMATION

1. VETERAN'S NAME:______________________________

   NICKNAMES OR ALIAS:______________________________

2. HOME ADDRESS:
   a. Street:______________________________
   b. City:____________________State:________Zip Code:__________
   c. Phone Number:______________________________

   LEGAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS)
   d. Street:______________________________
   e. City:____________________State:________Zip Code:__________
   f. Phone Number:______________________________

3. LOCATION OF VETERAN: HOME:________ HOSPITAL:________ NURSING HOME:__________

   IF OTHER THAN HOME, PROVIDE NAME, ADDRESS AND PHONE NUMBER OF THE FACILITY:
   a. Facility:______________________________
   b. Street:______________________________
   c. City:____________________State:________Zip Code:__________
   d. Phone Number:______________________________

4. VA CLAIM NUMBER:____________________ SS NUMBER:____________________

5. NAMES OF PERSONS DEPENDENT UPON (RELATIONSHIP / AGES)
   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________

6. NAME OF VETERAN REPRESENTATIVE:______________________________

   ADDRESS:______________________________

   HOME PHONE:____________________ WORK PHONE:____________________

7. PERSONAL PHYSICIAN:______________________________

   ADDRESS:______________________________

   PHONE:______________________________

8. HIGHEST LEVEL OF EDUCATION ACHIEVED:______________________________

9. USUAL OCCUPATION:____
DATE EMPLOYMENT ENDED:____

10. COUNTRY OF BIRTH:_________________________________STATE:__________

11. DATE OF BIRTH:_________________________CURRENT AGE:_________________

12. VETERAN SERVICE OFFICER (VSO):______________________________________
COUNTRY:____
VSO PHONE:__________________VETERAN IS IN RECEIPT OF NCS:_____________
PENSION AMOUNT:________________COMPENSATION AMOUNT:_____________

VETERAN OR RESIDENT REPRESENTATIVE:

______________________________ ______________________________
(Print Name: First, Middle, Last) (Date of Signature)

______________________________ ______________________________
(Signature of Veteran or Resident Representative) (Relationship to Veteran)

INFORMATION ON STATE CITIZENSHIP

Are you now domiciled in South Carolina and meet the citizenship requirements?________________

List the address or address where you have resided during the past two (2) years:

Address:____
City:____Country____________

Address:____
City:____Country____________

Address:____
City:____Country____________

Under penalty of Law, the undersigned swears or affirms that all answers to questions in this application are correct to the best of his/her knowledge, that all questions are fully understood, and that questions and answers have been read by the Veteran or read and explained to him/her and that the Veteran understands and accepts the terms and conditions required in Part II.

VETERAN OR RESIDENT REPRESENTATIVE:

______________________________ ______________________________
(Print Name: First, Middle, Last) (Date of Signature)

______________________________ ______________________________
(Signature of Veteran or Resident Representative) (Relationship to Veteran)

SOUTH CAROLINA STATE VETERANS HOMES

Authorization for Release of Protected Health Information

I, ______________________________ hereby authorize ____________________________
(Veteran/Veteran's Representative) (Name of Facility)

to release the entire record or portions thereof, on ________________________________
(Veteran's Name)

to the Admissions Coordinator of:

___ E. Roy Stone Veteran's Pavilion - 2200 Harden Street, Columbia, SC 29203

___ Richard M. Campbell Veterans Home - 4605 Belton Highway, Anderson, SC 29621

___ Veterans Victory House Nursing Home - 2461 Sidneys Road, Walterboro, SC 29488

___ Palmetto Patriots Home - 120 Hampshire Drive, Gaffney, SC 29342

___ Veteran Village - 1200 E. National Cemetery Road, Florence, SC 29506

in order to assist us in evaluating this individual for potential admission to the facility.

Veteran's Name ____

Veteran's Date of Birth ________________ Veteran's Social Security Number________________

The Authorization is valid for one year from the date of signing unless and earlier date, condition or event is specified here: ____

I understand that the information may include alcohol/drug abuse and/ or HIV/ARC and other infectious disease information. I do not want the following information disclosed:

____

I understand that information disclosed may be subject to re-disclosure by the above named facility. I may cancel this authorization at any time by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization it will not apply to information that has already been used or released to this authorization. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my authorization.

VETERAN OR VETERAN REPRESENTATIVE:

______________________________ ______________________________
(Print Name: First, Middle, Last) (Date of Signature)

______________________________ ______________________________
(Signature of Veteran/Veteran Representative) (Relationship to Veteran)

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* ______

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- ☐ HEALTH SUMMARY *(Prior 2 Years)*
- ☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: ______
- ☐ PROGRESS NOTES:
  - ☐ SPECIFIC CLINICS *(Name & Date Range)*: ______
  - ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: ______
  - ☐ DATE RANGE: ______
- ☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: ______
- ☐ LAB RESULTS:
  - ☐ SPECIFIC TESTS *(Name & Date)*: ______
  - ☐ DATE RANGE: ______
- ☐ RADIOLOGY REPORTS *(Name & Date)*: ______
- ☐ LIST OF ACTIVE MEDICATIONS: ______
- ☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: ______
- ☐ PNEUMONIA VACCINATIONS *(Dose, Lot Number, Date & Location)*: ______
- ☐ COVID-19 VACCINATION *(Dose, Lot Number, Date & Location)*: ______
- ☐ OTHER *(Describe)*: ______

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* ________________ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): ____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

SOUTH CAROLINA STATE VETERANS HOMES

APPLICATION FOR ADMISSION TO A STATE VETERANS HOME

Veteran's Name:____

Medical Record Number:____

The undersigned hereby makes application for admission of the above-named individual to a South Carolina State Veteran's Home, to receive nursing care.

___ E. Roy Stone Veterans Pavilion - 2200 Harden Street, Columbia, SC 29203

___ Richard M. Campbell Veterans Home - 4605 Belton Highway, Anderson, SC 29621

___ Veterans Victory House Nursing Home - 2461 Sidneys Road, Walterboro, SC 29488

___ Palmetto Patriots Home - 120 Hampshire Drive, Gaffney, SC 29342

___ Veteran Village - 1200 E. National Cemetery Road, Florence, SC 29506

It is understood and agreed that if admitted, the above-named individual and the person, if any, who makes this application on each individual's behalf, will obey and be bound by all rules and regulations governing the facility and its residents.

By making this application, the above-named individual and the person, if any, who makes this application on such individual's behalf give consent to said facility to administer such standard medical, surgical, dental, or other treatment as the attending physician recommends.

Consent is also given for the facility to disclose medical record information and/or release medical record documents to any outpatient provider and/or acute care hospital as needed to facilitate the provider in treating the above-named individual as referred by his attending physician, himself or his substitute decision maker.

Veteran:

________________________________ ________________________________

(Print Name: First, Middle, Last) (Date of Signature)

____

(Signature of Veteran)

Substitute Decision Maker:

________________________________ ________________________________

(Print Name: First, Middle, Last) (Date of Signature)

____

(Signature of Substitute Decision Maker)

SOUTH CAROLINA STATE VETERANS HOMES

ADVANCE DIRECTIVE INFORMATION

1. Does the Veteran have an Advance Directive such as Health Care Power of Attorney and/or Living Will?

   Yes:_______ No:_______

2. If yes, please attach a copy and complete the following:

   Designated Decision Maker:

   Name:_________________________ Relationship:_________________________

   Address:_________________________ Home Phone:_________________________

   _________________________ Business Phone:_________________________

3. Designee to receive personal property in the event of discharge/death?

   Name:_________________________ Relationship:_________________________

   Address:_________________________ Home Phone:_________________________

   _________________________ Business Phone:_________________________

4. Funeral Home:____

   Address:_________________________ Phone:_________________________

5. Has the Veteran completed an agreement consenting to provide a Body Donation?

   Yes:_________ No:________

   If yes, please attach a copy.

PART 2
MEDICAL INFORMATION

SOUTH CAROLINA STATE VETERANS HOME

Please give this packet to the Veteran's physician or medical staff.

This medical information will need to be completed and returned to the family/veteran to submit with the completed application. The application will be considered incomplete if all of the required information is not provided. An incomplete packet will delay the admission process. The information will be valid for 12 months only.

Note to the Physician

The State Veterans Nursing Home will NOT process applications without a COMPLETE medical certification. You MUST provide a signature on ALL 3 PAGES of the 10SH form. Additionally, all items MUST be acknowledged and question 29 must be answered. A MD is required to sign the 10-10SH on all 3 forms. FNP/ PA signatures (without a MD cosignatory) will not be accepted.

1. VA Medical Certification Form 10-10SH (all 3 pages)
2. SLUMS examination (1 page-VAMC Form) - Nursing/Social Work may complete and sign
3. PASARR (2 pages)- Nursing/ Social Work may complete and sign
    - Level II PASARR is required if diagnosis/history of MI and /or MR
4. Two step TST (copies of immunization records) The State Veterans Home will request the two (2) step Tuberculin Skin Test (TST) prior to admission to the home.
    - TST must be recorded as mm of induration and not as "positive" or ‘'negative"
    - If Veteran has positive TST or history, then a chest x-ray is indicated within 30 days of admission. Please include documentation of treatment, if any.
5. The following will also need to be included with the medical information
    - History and Physical
    - Last 6 months of Physician Progress notes
    - Inclusive Diagnosis/ Nursing/ Therapy notes
    - Recent discharge summaries from facilities
    - Current Medication Administration Record (MAR) or medication list
    - Current Immunization Records

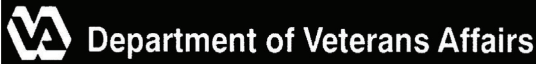
SOUTH CAROLINA STATE VETERANS HOMES

Please list information for any physician who currently provides medical care to the Veteran.
Last progress notes from all current physicians need to be attached.

POTENTIAL VETERAN NAME: ____

PHYSICIANS / PROVIDERS	NAME	ADDRESS	PHONE #	Upcoming Appointments
PRIMARY CARE PHYSICIAN				
DENTAL				
DERMATOLOGY (Skin)				
EAR/NOSE/THROAT				
G.I. (Gastrointestinal)				
NEPHROLOGY (Kidney)				
NEUROLOGY (Nervous System)				
OPTHALMOLOGY (Eye)				
ORTHOPEDICS (Bones)				
PODIATRY (Foot)				
PULMONOLOGY (Lungs)				
OTHER:				
CARDIOLOGY (Heart)				
PACEMAKER/DEFIBRILLATOR				
MODEL NAME:				
DATE IMPLANTED:				
PHYSICIAN/SURGEON:				

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019



VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY
2. DATE ADMITTED
3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)
4. RESIDENT'S NAME (Last, First, Middle) (Mandatory field)
5. SOCIAL SECURITY NUMBER (Mandatory field)
6. GENDER ☐ M ☐ F
7. AGE
8. DATE OF BIRTH (MM/DD/YYYY)
9. ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES
10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

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

11. HISTORY

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

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

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

CHECK ALL BOXES THAT APPLY OR CHECK N/A

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

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

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

36. REFERRING PHYSICIAN
37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS
39. TERTIARY DIAGNOSIS
40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN
41. TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE
42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY
43. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED
44. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

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

45. RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*

46. SOCIAL SECURITY NUMBER *(Mandatory field)*

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

47. SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN

48. DATE

PHYSICAL THERAPY ***(To be completed by Physical Therapist or Referring Physician)*** 49. Check if ☐ NEW REFERRAL ☐ CONTINUATION OF THERAPY

50. SENSATION IMPAIRED ☐ YES ☐ NO

51. RESTRICT ACTIVITY ☐ YES ☐ NO

52. PRECAUTIONS ☐ CARDIAC ☐ OTHER (Type other, specify)

53. FREQUENCY OF TREATMENT

54. TREATMENT GOALS:

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

55. ADDITIONAL THERAPIES ☐ O.T. ☐ SPEECH ☐ DIETARY

56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN

57. DATE

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

58. PRIOR LIVING ARRANGEMENTS

59. LONG RANGE PLAN

60. ADJUSTMENT TO ILLNESS OR DISABILITY

61. PRINT NAME OF SOCIAL WORKER

62. SIGNATURE OF SOCIAL WORKER

63. DATE

64. REMARKS

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

Department of Veterans Affairs

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART V - VA AUTHORIZATION FOR PAYMENT

65. RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*

66. SOCIAL SECURITY NUMBER *(Mandatory field)*

ADMINISTRATIVE REVIEW

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

68. DATE ADMITTED TO SVH

69. DATE RECEIVED BY VA

NURSING HOME CARE

70. SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70%:
☐ YES ☐ NO

71. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY:
☐ YES ☐ NO

72. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE:
☐ YES ☐ NO

73. APPROVED PER DIEM RATE:
☐ BASIC ☐ PREVAILING

ADULT DAY HEALTH CARE

74. ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE
☐ YES ☐ NO

DOMICILIARY CARE

75. DOES INCOME EXCEED THRESHOLD FOR AID & ATTENDANCE:
☐ YES ☐ NO

76. ELIGIBLE FOR PER DIEM PAYMENT FOR DOMICILIARY CARE:
☐ YES ☐ NO, ADDITIONAL ELIGIBILITY REQUIREMENTS

77. REMARKS:

78. SIGNATURE OF VA ADMINISTRATIVE REVIEWER

79. DATE

CLINICAL REVIEW

80. SERVICE CONNECTED CONDITION BEING ADMITTED FOR:

NURSING HOME CARE

81. IS VETERAN BEING ADMITTED DUE TO SC CONDITION:
☐ YES ☐ NO

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

DOMICILIARY CARE

83. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY:
☐ YES ☐ NO

84. DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL EMPLOYMENT:
☐ YES ☐ NO

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

ADULT DAY HEALTH CARE

86. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE (38 U.S.C. 1720.(F)(1)(A))
☐ YES ☐ NO

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

88. REMARKS

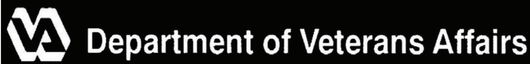
89. SIGNATURE OF VA PHYSICIAN/APRN/PA

90. DATE

PAPERWORK REDUCTION ACT OF 1995 AND PRIVACY ACT STATEMENT

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. 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 maybe entitled. This information is collected under the authority Of Title 38 CFR Parts 51 and 52. 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.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Jan 31, 2016



VA FORM 10-10SH INSTRUCTIONS FOR
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

As a condition for VA approved State Veterans Home (SVH) receive payment of per diem, the State home must submit to the VA medical center of jurisdiction for each veteran a completed VA Form 10-10SH, State Home Program Application for Care--Medical Certification and a 10-10EZ, Application for Health benefits or 10-10EZR, Health Benefits Renewal Form. This form must be submitted at the time of admission and with any request for a change in the level of care (domiciliary, nursing home care or adult day health care).

PART I-ADMINISTRATIVE
This section must be completed in full by State Veterans Home designated staff.

1. STATE HOME FACILITY - Enter the name of the facility
2. DATE ADMITTED - Select the date admitted using the calendar or enter the date as MM/DD/YYYY
3. STATE HOME FACILITY ADDRESS - Enter complete address
4. RESIDENT'S NAME - Enter the full name of the person to whom this application applies
5. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant
6. GENDER - Check the appropriate box
7. AGE - Age of applicant
8. DATE OF BIRTH - Enter the date of birth in the format MM/DD/YYYY
9. ADVANCED MEDICAL DIRECTIVE - Check No or Yes
10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS? Check Yes or No

PART II-HISTORY AND PHYSICAL

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

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

PART III - EVALUATION (To be completed by SVH)

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

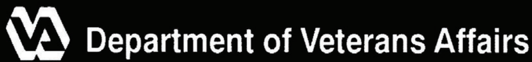
PHYSICAL THERAPY

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

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

58. PRIOR LIVING ARRANGEMENTS
59. LONG RANGE PLAN
60. ADJUSTMENT TO ILLNESS OR DISABILITY
61. PRINT NAME OF SOCIAL WORKER
62. SIGNATURE OF SOCIAL WORKER
63. DATE
64. REMARKS

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Jan 31, 2016



VA FORM 10-10SH INSTRUCTIONS FOR
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART V - VA AUTHORIZATION FOR PAYMENT
Completed in full by VA Medical Center of Jurisdiction designated staff

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

ADMINISTRATIVE REVIEW SECTION

67. 10-10EZ OR 10-10EZR RECIEVED WITH 10-10SH - Check the appropriate if the forms were received with the 10-10SH or if the forms were completed electronically.
68. DATE ADMITTED TO SVH - Enter the date the Veteran was physically admitted to the State Veteran's Home
69. DATE RECEIVED BY VA - Enter the date the complete admission application was received by the VA.

NURSING HOME CARE

70. SERVICE CONNECTED CONDITION RATING GREATER OR EQUAL TO 70% - Check YES or NO if the Veteran is 70% SC.
71. DOES VETERAN HAVE A RATING OF TOTAL DISABILITY BASED ON INDIVIDUAL UNEMPLOYABILITY? Check YES or NO.
72. ELIGIBLE FOR PER DIEM PAYMENT NURSING HOME CARE - Check YES or NO
73. APPROVED PER DIEM RATE - Check either Basic or Prevailing rate.

ADULT DAY HEALTH CARE

74. ELIGIBLE FOR PER DIEM PAYMENT FOR ADULT DAY HEALTH CARE - Check YES or NO.

DOMICILIARY CARE

75. DOES INCOME EXCEED THRESHOLD FOR AID AND ATTENDANCE? Indicate if the Veteran's annual income exceeds the maximum amount of someone in receipt of Aid & Attendance for the following categories: Single Veteran, Veteran with Spouse/Dependent, Two Veterans Married to Each Other, Surviving Spouse, or Surviving Spouse with One Dependent.
76. ELIGIBLE FOR PER DIEM PAYMENT DOMICILIARY CARE - Enter YES if eligible and NO is there are additional eligibility requirements
77. REMARKS - Enter any remarks regarding this section.
78. SIGNATURE OF VA ADMINISTRATIVE REVIEWER-Enter signature
79. DATE - Date VA Administrator signed

CLINICAL REVIEW SECTION

80. SERVICE CONNECTED CONDITION BEING ADMITTED FOR - If necessary, review VA databases such as VISTA, HINQ, VIS or CPRS for Veteran's service-connection condition/rating. If the reason the Veteran is being admitted to the nursing home is a SC condition, enter the service-connected condition the Veteran is being admitted for.

NURSING HOME CARE

81. IS VETERAN BEING ADMITTED DUE TO SERVICE CONNECTED CONDITION? Check YES or NO.
82. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE? Check YES or NO.

DOMICILIARY CARE

83. DOES VETERAN HAVE MEANS TO PROVIDE FOR SELF OR PROVIDED FOR IN THE COMMUNITY? Check YES or NO.
84. DOES HEALTH AND/OR FUNCTIONAL DEFICITS RENDER VETERAN UNABLE OF PURSUING SUBSTANTIALLY GAINFUL EMPLOYMENT? Check YES or NO. If Veteran is unable to pursue substantially gainful employment and the clinical provider (reviewer) determines the Veteran has health and functioning deficits that require domiciliary care in the SVH and the Veteran is capable of performing the following daily living activities:
    (1) Perform without assistance daily adulations, such as brushing teeth, bathing, combing hair, and body eliminations.
    (2) Dress self, with minimum of assistance.
    (3) Proceed to and return from the dining hall without aid.
    (4) Feed self.
    (5) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.
    (6) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.
    (7) Share in some measure, however slight, in the maintenance and operation of the facility.
    (8) Make rational and competent decisions as to his or her desire to remain or leave the facility.

    If all the above conditions are met, check "Yes" in the appropriate box. If these conditions are not met, check "No". If any of the above questions are answered "No", per diem is not approved.
85. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE? Check Yes or No.

ADULT DAY HEALTH CARE

86. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE: (38 U.S.C. 1720, (F)(1)(A))? Check YES or NO.
87. VETERAN APPROVED FOR ADULT DAY HEALTH CARE? Check YES or NO.
88. REMARKS - Enter any remarks regarding this section.
89. SIGNATURE OF VA PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE (APRN) OR PHYSICIAN ASSISTANT (PA) - Enter Signature
90. DATE - Date VA Physician/APRN or PA signed

Additional Information for completing the 10-10SH application…..

Answer all questions in the appropriate sections. If you need more space to answer a question, please attach a sheet of paper to the form containing the Veteran's name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - LEVEL I SCREENING FORM

Name:	Date of review:
SSN:	Location at assessment:
Medicaid: Non-Medicaid:	CLTC#:
Date of birth:	Referral source:
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		
2. IQ tested below 70?		
3. Was time of test prior to age 22?		
4. Does client have 3rd grade education? If not, state reason in Comments Section.		
5. Adaptive behavior: Could client ever perform self care activities?		
- Did he/she help care for spouse/parents/children?		
- Was client ever able to cook and perform household duties?		
- Was client gainfully employed? If not, explain in Comments Section.		
- Did client have driver's license?		
6. Cognitive Functioning:		
- Memory: Does Client remember what he/she had for breakfast or lunch?		
- Simple math: Can client add 12 + 8?		
- Concept formation: Can client describe the different between a fish and dog?		

7. Comments: ____

____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No_____ Yes_____ Diagnosis: ______________________

2. History of psychiatric hospitalization within previous two years. *(Give dates of treatment)* If no hospitalization, indicate here: ____

____/____/____ to ____/____/____ ____/____/____ to ____/____/____ ____/____/____ to ____/____/____

3. Current behavioral indicators:

Attempted suicide ___
Assaultive ___
Incessant loud talking ___
Uncooperative ___
Hostile ___
Unrealistic fear of strangers ___
Self-mutilation ___
Combative ___
Social isolation ___
Destruction of property ___
None of these indicators: ___

4. Comments: (Include explanation of major symptoms): ______________________

____

Name: ______________________________ SSN: ______________________________

III. LIST ALL PSYCHOTROPIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

IV. RECOMMENDATION OF REVIEWER:

_____ Recommend further evaluation based on mental retardation indicators.

_____ Recommend further evaluation based on mental illness indicators.

_____ No further evaluation recommended.

_____ No further evaluation recommended, but indicators present. (State reasons below)

____

____

Comments: (Give justification for above recommendations, if needed.)

____

____

V. PERTINENT INFORMATION

_____ IMD admission requested; if so, indicate facility: ______________________________

_____ Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: ______________________________ CLTC Area# ______

Signature and title of assessor: ______________________________

Agency/Institution completing form: ______________________________

Admitting Nursing Facility: ______________________________Date of Admission(if known) ________

FOR CLTC/IOC USE ONLY

FOR CLTC USE ONLY

Reviewed by Nurse Consultant ______(initials)

Date reviewed: ____________

VI. ADVANCE CATEGORICAL DETERMINATION

_____ Advance categorical determination that specialized in services are not required:

- _____ 1. Severity of physical impairments overides need for specialized services (MI only)
- _____ 2. Nursing facility respite not to exceed 14 days (MR or MI)
- _____ 3. Emergency admission due to suspected abuse/neglect under authority of DSS (MR or MI)
- _____ 4. 30-Day time limited certification (MR or MI)
- _____ 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant: ______________________________

Date sent to nursing facility: ______________________________ Initials: ______________

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu

Name____________________________ Age______________

Is the patient alert?______________ Level of education______________________

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

(1) **How much did you spend?**

__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.

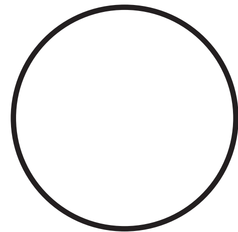
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember? 1 point for each one correct.**

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.

__/2 (0) 87 (1) 648 (1) 8537

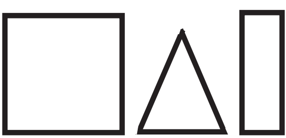
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay

__/4 (2) Time correct

(1) **10. Please place an X in the triangle.**



__/2 (1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) **What was the female's name?** (2) **What work did she do?**

__/8 (2) **When did she go back to work?** (2) **What state did she live in?**

______ **TOTAL SCORE**

SCORING		
High School Education		Less than High School Education
27-30	Normal	25-30
21-26	Mild Neurocognitive Disorder	20-24
1-20	Dementia	1-19

CLINICIAN'S SIGNATURE __________ DATE __________ TIME __________

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.