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RESCISSIONS

The following material is rescinded.

COMPLETE RESCISSIONS

a. Manuals

M-1, part I, changes 25, 95, 128, 129, 132, 138 and 140.

M-1, part I, chapter 4, dated March 8, 1971, and changes 1 through 6.

M-1, part I, chapter 4, dated March 14, 1979, and changes 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.

M-1, part I, chapter 4, dated March 16, 1989.

b. Interim Issues

II 10-68-38	II 10-82-47
II 10-70-18	II 10-82-57
II 10-71-30	II 10-84-10
II 10-72-6	II 10-84-13
II 10-72-18	II 10-84-32
II 10-72-19	II 10-86-4
II 10-73-1	II 10-87-4
II 10-73-5	II 10-87-10
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II 10-81-40	
II 10-81-56	
II 10-81-61 and Supp. No. 1	
II 10-81-62 and Supp. No. 1	
II 10-82-7 and Supp. No. 1	

c. Circulars

10-78-150
10-79-158
10-80-201
10-84-66
10-86-71 and Supp. Nos. 1 and 2
10-88-21
10-88-38

CHAPTER 4. ADMISSIONS -- HOSPITAL AND DOMICILIARY CARE**SECTION I. GENERAL****4.01 BASIC POLICY**

a. All applicants for VA (Department of Veterans Affairs) medical care must complete VA Form 10-10, Application for Medical Benefits, and the attachment to computer-generated VA Form 10-10, Consent to Release Information, for insurance purposes. Both forms are to be printed and signed any time the veteran is admitted to inpatient care. The VA Form 10-10 must be printed and signed when any changes occur. The attachment to computer-generated VA Form 10-10, Consent to Release Information, must be printed and signed (if patient agrees) when any changes occur on the VA Form 10-10i, Insurance Information. VA Form 10-10F, Financial Worksheet, and VA Form 10-10i will be completed as appropriate. These applications for medical treatment or domiciliary care will be given prompt attention. Veterans with VA rated service-connected disabilities will be given priority over all applicants except those presenting with a bona fide medical emergency. In non-emergent cases, the forms will be completed prior to the veteran receiving a medical evaluation. Action will be completed on applications received by mail within an average of 2 working days. Applicants who appear in person will be given a medical examination promptly to determine need for care. Applicants who have been previously scheduled for admission, either from OPT (Outpatient Treatment)-PBC (pre-bed care) or from the waiting list, will report directly to the admission activity and will be taken immediately to the ward with previously prepared medical records. Reexamination by a physician is unnecessary and when a patient reports for such a scheduled admission, no count will be taken as an outpatient visit. After the examination of the applicant or the evaluation of mailed in application, one of the following actions will be taken:

- (1) A decision will be made to admit at once or place on an ambulatory care status to obviate the need for hospital treatment.
- (2) The applicant who is physically present will be scheduled for admission and provided a reporting date if a bed will be available within 15 calendar days. Veterans who mailed in their applications to the facility will be scheduled for a medical evaluation and advised in writing.
- (3) The applicants will be placed on PBC.
- (4) The applicants will be placed on the waiting list.
- (5) The applicant will be determined as not in need of hospitalization. If a conclusive determination cannot be reached on the day of the examination, the patient will be admitted for observation or scheduled for admission and placed in PBC status.

b. During non-duty hours, the Director will designate the AOD (Administrative Officer of the Day) as their representative. As the highest administrative authority on duty, the AOD will be the final authority for all non-medical decisions. The AOD will make decisions in accordance with local policy and precedents which have been established by the medical center Director. Each medical center will establish policy which will clearly define the duties and responsibilities of the AOD. This policy will include guidelines indicating when off-duty personnel will be called in, when a preliminary investigation of any unusual patient incident should be conducted, and the

provision of technical direction to medical center staff ensuring that procedural, legal, and administrative requirements relating to patient care are met. The policy will give the AOD authority to provide administrative direction to physicians and other staff for non-medical treatment issues including the legal and administrative implications of medical decisions. The AOD is expected to use sound judgment and contact appropriate off-duty personnel for guidance when issues arise for which there is no policy or precedent established, or when issues arise which will have an impact beyond the medical center or may reflect unfavorably upon the medical center.

c. Applicants appearing acutely ill will be taken directly to an examining room, and administrative details will be accomplished later.

d. Medical or psychiatric applicants who are eligible only under 38 CFR (Code of Federal Regulations) 17.46(c)(1) as medical emergencies will be admitted for humanitarian reasons if referral to an available non-VA hospital would, in the judgment of the VA physician, jeopardize their health or life. The applicant, or a representative, will be advised prior to admission or as soon as possible thereafter, that VA will charge for the services rendered as defined in M-1, part I, chapter 15.

e. Consultants should be available to assist the admitting physician in deciding whether to admit an applicant. The admitting physician's decision to admit a patient will not be overruled. When there is a difference of opinion between the admitting physician and the treating physician as to the need for hospitalization, the treating physician, upon conclusion of an examination, may discharge the patient, but will not cancel the admission.

f. VA policy on priorities for hospital and domiciliary care are contained in paragraph 4.26. In applying these priorities, care will be exercised to assure that applicants who apply in person are not given preference over higher priority applications on the waiting list. Veterans seeking care for service-connected disabilities will be accorded priority in all aspects of professional and administrative processing except when compelling medical reasons require that services be given more expeditiously to an emergent medical or psychiatric patient.

g. Physicians, nurse practitioners, physician assistants, clinical psychologists, having clinical privileges at the VA medical center may authorize admission to that VA facility if they are licensed to do so in the State where the VA facility is located.

4.02 ADMISSION OF APPLICANTS

a. Except for veterans with SCIs (spinal cord injuries), eligible applicants who need hospital or domiciliary care will be admitted to the VA health care facility nearest their location which is adequately equipped and staffed to furnish the needed care within a reasonable period of time.

b. Veterans requiring care for treatment of a SCI condition will normally be admitted to the nearest VA health care facility with a VA Central Office approved SCI Service having facilities to provide appropriate care.

c. If admission to a VA health care facility with a VA Central Office approved SCI Service is not feasible, the patient will be admitted to the nearest VA health care facility with the expertise and facilities to treat the SCI until such time that transfer to an appropriate VA SCI Center facility can be accomplished.

d. If neither of the procedures outlined in subparagraph b or c is feasible and the veteran requires treatment of a SC (service-connected) SCI, or of a SCI for which discharged or released from the active military, naval or air service, arrangements for appropriate care in a community facility, at VA expense, will be effected pending placement in a VA SCI Center facility.

e. SCI patients requiring treatment for a non-spinal cord injury condition may, in a medical or psychiatric emergency, or if a bed is not available at the nearest VA facility with a SCI Service, be admitted to a non-spinal cord injury facility. The veteran will then be transferred to a VA facility with a SCI Service if it is anticipated that extended care will be required (30 or more days).

f. If the application is made at, or is received by, a health care facility which cannot meet the preceding requirements in subparagraphs a through c, personnel at that facility are responsible for referring the application to the nearest VA health care facility which can meet the requirements. The most expedient means of communication will be used to determine the nearest appropriate health care facility. Referral of an emergent medical or psychiatric case will not be delayed for the purposes of paperwork processing. Special attention will be given to veterans with new SCIs (traumatic/or non-traumatic) and admission to the appropriate health care facility will not be delayed more than 48 hours following receipt of the application.

g. Patients being treated in the renal dialysis unit will be recorded as an outpatient visit rather than a 1-day admission.

4.03 VETERANS OF CZECHOSLOVAKIA OR POLAND

General policies and procedures for this category of veteran may be found in M-1, part I, chapter 24, section III.

4.04 ADMISSION OF APPLICANTS REFERRED BY PHYSICIANS

a. **Purpose.** This paragraph provides policy concerning disposition of applicants referred for admission by other physicians, either from within the VA system, i.e., other VA medical centers or outpatient clinics, or from non-VA physicians.

b. **Referral by a VA Physician.** Admission responsibility, and hence the final disposition of all cases, rests ultimately with the physician assigned this responsibility at the facility where the application is received. Field facilities which initially receive applications or requests for hospitalization of eligible VA beneficiaries are responsible for furnishing needed care or making necessary arrangements with other VA facilities for admission. This responsibility often involves critical life and death decisions and is to be regarded with the utmost gravity. The effectiveness of the VA medical care system is affected to a large extent by the professional skill and judgment with which this responsibility is discharged. Applicants referred for hospital admission by a VA physician from another VA medical center or outpatient clinic will normally not be reexamined. The veteran should be admitted on the strength of the examining physician's findings and discharged when inpatient care is no longer required. When, in the opinion of the responsible VA physician at the VA medical center to which the veteran was referred, the need for admission is clearly not supported by documented medical findings, the veteran may be reexamined. The veteran will not be refused admission based on this reexamination unless approved by a VA staff physician. Medical findings and a report of the reason for non-admission will be well documented and will remain with the application and supporting documents.

c. **Referral by Non-VA Physician.** An eligible VA beneficiary referred for hospitalization by a non-VA physician will normally be admitted. If, after medical evaluation by a VA physician, the applicant is not admitted, a telephone call will be made to the non-VA physician by the responsible VA physician explaining the reasons, and what action VA recommends. Every effort should be made to reach a mutual understanding and agreement with the referring physician. In every case when hospitalization is not necessary, the admitting physician will document adequately (with consultation, laboratory, X-ray results, etc., when indicated), the reasons for deciding against hospitalization. When there are abnormal findings or if other circumstances warrant, the admitting physician should convey this information to the referring physician by a direct telephone call, or by mail, with appropriate assistance from MAS (Medical Administration Service). Telephonic inquiries will be processed according to instructions in paragraph 4.34.

d. **Question of Need.** In every instance, the admitting physicians will resolve questions of doubt in favor of admission of veterans referred by either VA or non-VA physicians (subpar. b or c). When in the opinion of the admitting physician the applicant does not require immediate admission, consideration will be given to rescheduling the applicant for admission within 15 days, placing the applicant on PBC or ambulatory care to obviate the need for hospital care. If scheduling for admission or placement on the waiting list is not appropriate, but findings indicate hospitalization will probably be required at a later date, the veteran will be asked to reapply. Service-connected veterans and other high priority groups require particular attention in accordance with long-standing VA policies. Non-committed patients have the right to refuse admission, and this refusal should be adequately documented in the medical record.

e. **Not in Need of Medical Care.** Applicants who are determined to be in need of social assistance rather than medical care will be referred to Social Work Service.

4.05 HOSPITALIZATION FOR EFFECTS OF ALCOHOL, DRUG ABUSE OR AIDS

Requests for hospitalization for the treatment of alcoholism, drug abuse, or AIDS (Acquired Immune Deficiency Syndrome) will be medically and administratively processed in the same manner as requests for admission for treatment of any other disability, disease or defect. Also, those eligible veterans who are alcohol or drug abusers or who have AIDS and who are suffering from other medical disabilities shall not be discriminated against in admission or treatment, solely because of their alcohol or drug abuse or dependence, or their AIDS condition.

4.06 RECEPTION AND ROUTING OF APPLICANTS AND PATIENTS

General policies and procedures for these activities are stated in M-1, part I, chapter 17.

4.07 AVAILABILITY OF MEDICAL RECORDS

a. Previous medical and outpatient records existing at the facility will be made available to admitting and examining physicians. If it has been determined that a patient has received prior care at another VA facility or other healthcare facility, records (which may include copies) will be requested. Further instructions regarding the transfer/requesting/releasing of medical records can be found in M-1, part I, chapters 5 and 9.

b. All medical and administrative records pertaining to the patient must be maintained in the appropriate medical record folder. If these folders do not exist, one will be created and filed in the File Room. Further instructions regarding the creation of medical record folders can be found in M-1, part I, chapter 5.

4.08 PROCESSING DEAD-ON-ARRIVAL CASES

a. **General.** A person who is dead on arrival will not be shown on hospital records either as a gain or a loss.

b. **Admission Authorized.** A veteran who had been authorized admission and is dead on arrival will be considered as having been constructively hospitalized by VA. A CHR (consolidated health record) will be established consisting of the application for hospitalization completed to the extent possible, copy of the death certificate, and VA Form 10-2829, Telephonic Authorization, or other document which authorized admission. The next of kin will be contacted and local authorities notified, if appropriate.

c. **Admission Not Authorized.** A person who had not been authorized admission and is dead on arrival will not be considered as having been constructively hospitalized. The next of kin, and the coroner or equivalent, will be notified immediately. Disposition of the remains will be made in accordance with instructions of the next of kin, unless stipulated by the coroner. Mortuary services will not be authorized. The Chief, MAS, will take precautions to safeguard any funds and effects until they can be released to the proper person. A VA Form 119, Report of Contact, supported by such other documents as necessary will be prepared relating all pertinent information. Transportation of remains will not be authorized by the facility, and the provisions of paragraph 4.62 concerning disposition of unclaimed funds and effects are not applicable. All administrative and medical documents prepared for the person who is dead on arrival will be filed in the person's CHR. When these folders do not exist, action will be taken to establish a CHR.

4.09 MAINTENANCE OF PERPETUAL BED INVENTORY

A perpetual bed inventory will be maintained in the DHCP (Decentralized Hospital Computer Program) for use by the admitting physician. Local instructions will provide that information regarding interward transfers and discharges be promptly input into the DHCP.

4.10 APPLICATION PROCESSING TIME STUDIES

The Application Processing Time study will be produced by DHCP and/or manual tracking, when necessary. The time study should be run at least quarterly and more frequently if a need exists. The Chief, MAS, will analyze the time study and the findings will be furnished to the Director. Procedures to be followed are found in appendix 4B.

4.11 PATIENT IDENTIFICATION

a. All VA health care medical centers will issue patient ID (identification) bands to all persons immediately on their admission as bed occupants, except domiciliary patients who will be issued VA Form 10-5510, Photo Identification for Domiciliary Patients. An

ID band must be worn by all inpatients in VA facilities and VA nursing home care units. The wearing of ID bands is mandatory in the interest of the personal security and welfare of each patient. The ID band will contain the patient's full name and ID number. Additional information, e.g., ward designation is optional. If the ward designation is used, it will refer only to the ward number and will not make reference to its professional service specialty.

b. Domiciliary patients will not be required to wear ID bands. VA Form 10-5510 containing the patient's photograph, name and ID number will be the only ID required for domiciliary patients.

4.12 REVIEW OF APPLICATIONS

A review of all the previous day's applications which indicate that no care was required, or which were canceled, will be conducted each morning by the designee of the Chief of Staff. The review will serve to identify possible errors in judgment whereupon the patient may be reevaluated and appropriate treatment instituted.

4.13 NOTIFICATION OF ADMISSION OF ACTIVE DUTY NAVY AND MARINE CORPS PERSONNEL

The appropriate Navy OMA (Office of Medical Affairs) will be notified of the admission of active duty Navy and Marine Corps personnel (other than those referred through ASMRO (Armed Services Medical Regulating Office)). The notification will be by teletype to the appropriate Navy Regional OMA that has jurisdiction over the area in which the VA health care facility is located. The admission notification will include a request for an official treatment authorization to be used for billing purposes. The addresses and commercial telephone numbers of the seven Navy Regional OMA and the areas over which they have jurisdiction are:

a. **Northeast Region.** States of Connecticut, Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, and Wisconsin medical responsibilities are vested in:

Commander
Naval Medical Command, Northeast Region
Building 38-H, Code 03B1
Great Lakes, IL 60088-5200
Tel: 312-688-3978

b. **National Capital Region.** States of Maryland and West Virginia; the Virginia counties of Arlington, Fairfax, Loudoun, and Prince William; the Virginia cities of Alexandria, Falls Church, and Fairfax; and the District of Columbia responsibility for medical matters is vested in:

Commander
Naval Medical Command, National Capital Region
Building 54, Code 112
Bethesda, MD 20814-5000
Tel: 202-295-0518.

c. **Mid-Atlantic Region.** For the Territory of Puerto Rico; the States of North Carolina and South Carolina; and all areas of Virginia, South and West of Prince William and Loudoun counties responsibility for medical matters is vested in:

Commander
Naval Medical Command, Mid-Atlantic Region
Code 11F
6500 Hampton Boulevard
Norfolk, VA 23508-1297
Tel: 804-444-4350.

d. **Southeast Region.** For the States of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas medical responsibility is vested in:

Commanding Officer
Naval Medical Command, Southeast Region
P.O. Box 140, Code 112
Jacksonville, FL 32214-5222
Tel: 904-777-7902.

e. **Southwest Region.** For the States of Arizona, Nevada, and New Mexico; the counties of Kern, San Bernardino, San Luis Obispo, Santa Barbara, and all other California counties South thereof, medical responsibility is vested in:

Commander
Naval Medical Command, Southwest Region
Code 011
San Diego, CA 92134-7000
Tel: 619-233-2948.

f. **Northwest Region.** The States of Alaska, Colorado, Idaho, Kansas, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming; and the counties of Inyo, Kings, Tulare; and all other counties of California North thereof and NAS Fallon, Nevada, medical responsibility is vested in:

Commander
Naval Medical Command, Northwest Region
Building 62B
8750 Mountain Boulevard
Oakland, CA 94627-5025
Tel: 415-633-6200.

g. **Pacific Region.** For the State of Hawaii; and the Republic of the Philippine Islands responsibility for medical matters is vested in:

Commander
Naval Medical Command, Pacific Region
Office of Medical Affairs
Naval Air Station
Barbers Point, HI 96862
Tel: 808-684-2294.

4.14 RESPITE CARE

a. The term "respite care" means hospital or nursing home care which:

(1) Is of limited duration;

(2) Is furnished in a VA facility on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home; and,

(3) Is furnished for the purpose of helping the veteran to continue residing primarily at home.

b. VA medical centers may provide respite care to eligible veterans for up to 30 days in a calendar year for each veteran. The frequency of the respite care will not exceed once a quarter. The duration of any one respite care admission will not exceed 14 days. Respite care may be provided either in a VA hospital or VA nursing home setting.

**4.15 DECISIONS AND NOTICES OF DECISIONS DENYING HEALTH CARE RELATED BENEFITS
(Also see M-1, pt. I, ch. 1, sec. X).**

a. Each facility will develop written policy and procedures to ensure that any veteran denied health care related benefits (other than clinical) is properly notified of the reason for that denial and will inform the veteran of the appeal process. The notice shall include an explanation of the procedure for obtaining review of the decision.

b. If the benefit is denied based on a medical determination (e.g., a physician determines that care is unnecessary) the veteran need only be informed of the reason for denial. A notice of appeal rights should not be sent because the veteran cannot appeal such a denial to the BVA (Board of Veterans Appeals).

c. All denial notices shall include:

(1) Statement of the reason for the decision;

(2) Summary of evidence considered; and

(3) Explanation of the procedure for obtaining review of the decision. In all cases, information provided shall be sufficient to enable the veteran or the veteran's representative to pursue any further appropriate action regarding the issue.

d. Each facility has the discretion to implement the procedure(s) to comply with due process requirements which would be most practical for their situation. Generally, when a health care related benefit is sought in writing (i.e. claim for unauthorized medical expenses) and denied, notice of denial and appellate procedure will be provided in writing. If the benefit is sought in a face-to-face setting (i.e., claim for beneficiary travel), then the denial may be made orally. In either case, VA Form 1-4107, Notice of Procedural and Appellate Rights, will be provided to the veteran or their representative. In all cases, the beneficiary's CHR must be adequately documented to show that notice was given. Locally developed and approved overprinted forms, rubber stamps, or simple chart documentation, with the following wording may be used:

Patient has been given VA Form 1-4107, Notice of Procedural and Appellate Rights. Benefit applied for: _____

Date: _____ Signature: _____

SECTION II. ELIGIBILITY

4.16 GENERAL

a. Inpatient care may be furnished at facilities under the direct jurisdiction of the Secretary to those classes of persons listed in 38 CFR 17.45, 17.46, and 17.47.

b. Public Law 99-272, The Veterans Health Care Amendments of 1986, as amended by Public Law 101-508, The Omnibus Budget Reconciliation Act of 1990, established two categories of eligibility for VA health care:

- (1) Mandatory, and
- (2) Discretionary.

c. The law established income levels for determining whether nonservice-connected veterans are eligible for cost-free VA medical care. These income levels are adjusted on January 1 of each year by the percentage that VA pension benefits are increased.

d. The law provides that, VA shall furnish needed hospital care, and may furnish needed nursing home care to veterans in the "mandatory" category, to:

- (1) Any veteran who has a service-connected disability for any disability;
- (2) Any veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty for any disability;
- (3) Any veteran who, but for a suspension pursuant to 38 U.S.C. (United States Code) 1151 (or both suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;
- (4) Any veteran who is a former POW (prisoner of war), for any disability;
- (5) Any veteran who served in Vietnam during the Vietnam era who may have been exposed to Agent Orange or other toxic substance, and requires care for a disability possibly related to such exposure;
- (6) Any veteran who was exposed while on active duty to ionizing radiation from nuclear testing or participation in the American occupation of Hiroshima and Nagasaki following W.W.II and who are in need of care for a condition possibly related to such exposure;
- (7) Any veteran of the Mexican Border Period, or World War I, for any disability; and
- (8) Any nonservice-connected veteran if the veteran is unable to defray the expenses of necessary care which is defined as:
 - (a) Having proof of receiving assistance under a State plan (MEDICAID) approved under Title XIX of the Social Security Act;
 - (b) Being in receipt of VA pension or;
 - (c) Having attributable income not exceeding the mandatory income threshold amounts.

e. With respect to veteran with "mandatory eligibility," directors of VA health care facilities shall ensure that:

(1) If the veteran is in immediate need of hospitalization, care will be furnished at the VA facility where the veteran applies, or if that facility is incapable of furnishing care, arrange to admit the veteran to the nearest VA medical center or DOD (Department of Defense) hospital with which the VA has a sharing agreement under 38 U.S.C. 5011, VA/DOD Sharing, that can provide the needed care. If VA or DOD (Department of Defense) facilities are not available, arrange for care on a contract basis if the veteran is eligible under 38 U.S.C. 1703, to receive hospital care in non-VA facilities.

(2) If the veteran is not in need of urgent or emergent medical or psychiatric hospitalization, and a bed is not immediately available, schedule the veteran for admission at the VA facility where the veteran applies. If the schedule does not permit admission in a timely manner, refer the veteran for admission or scheduling for admission to the nearest VA medical center or DOD facility with which the VA has a sharing agreement under 38 U.S.C. 5011 (VA/DOD Sharing).

(3) A veteran in the "mandatory" category shall not be denied admission to hospital care if the care can be provided at some health care facility in the VA system. All medical centers should have a patient referral policy in place.

f. VA health care facilities may provide hospital and nursing home care to veterans in the "discretionary" category if space and resources are available in VA facilities and the veteran agrees to pay VA co-payments for their care.

g. VA shall charge applicants with discretionary eligibility a copayment determined in accordance with procedures contained in appendix 4D. "Discretionary" veterans who do not agree to pay co-payments to VA are not eligible for VA medical care and may be treated only on the basis of a humanitarian emergency.

4.17 MINIMUM ACTIVE DUTY REQUIREMENT

a. Persons (see other categorized in subpar. b) who originally enlisted in a regular component of the Armed Forces after September 7, 1980, or who entered on active duty after October 16, 1981, are not eligible for benefits administered by VA unless they completed the lesser of:

- (1) Twenty-four continuous months of active duty, or;
- (2) The full period for which such person was called or ordered to active duty.

b. The minimum active duty requirements specified in subparagraph 4.17a. do not apply to the following classes of individuals:

- (1) Those who are discharged or released from active duty for:
 - (a) Reasons of early-out (10 U.S.C. 1171).
 - (b) Reasons of hardship (10 U.S.C. 1173).
 - (c) Disability incurred or aggravated in line of duty.

(2) Persons who have a compensable service-connected disability.

(3) Those who entered on active duty after October 16, 1981, and who had previously completed a continuous period of active duty of at least 24 months or who had been discharged or released from such period of duty for reasons of early-out.

c. Persons who do not meet the minimum active duty requirements and have an adjudicated, SC disability may be provided medical benefits for or in connection with that specific disability and are eligible for medical care in the same manner as any other veteran who served on active duty. Entitlement to class II dental benefits does not require adjudication action when the provisions of 38 CFR 17.123a, are met.

d. A discharge under 10 U.S.C. 1171, is an "early-out" discharge available to enlisted persons only (and not to officers), which must be granted within 90 days before the expiration of the term of enlistment or extended enlistment. For example, with a 2-year period of enlistment, a discharge under 10 U.S.C. 1171, may only be granted after the person has served at least 21 months; for a 3-year enlistment, only after at least 33 months have been served, etc. Since the 24-month requirement would already be met in the second situation, it is only the 10 U.S.C. 1171, discharge for a 2-year enlistment which is of concern to VA in determining entitlement to VA benefits. Only the Army has a minimum 2-year period of enlistment. It is most important that the DD Form 214, Report of Separation from Active Duty, be reviewed very carefully to determine if a discharge under 10 U.S.C. 1171, has been granted when an Army veteran has less than 24 months active duty service and none of the other exceptions listed under subparagraph b or c apply.

(1) The majority of Army discharges under 10 U.S.C. 1171, will have the narrative reason "Overseas Returnee" on the DD Form 214. If the individual served at least 21 months active duty and the narrative reason for separation on the DD Form 214 shows "Oversee Returnee," it will be accepted as proof of discharge under 10 U.S.C. 1171.

(2) If an Army veteran served at least 21 months and any other narrative reason for separation (including one considered to be for the convenience of the Government) is shown on the discharge form, an inquiry to the regional office of jurisdiction will be initiated for a determination as to whether or not the separation was under 10 U.S.C. 1171. Other narrative reasons the Army may use for discharges under 10 U.S.C. 1171, include:

- (a) Assignment to installation or unit scheduled for inactivation or permanent change of station;
- (b) Separation from medical holding detachment/company;
- (c) Physical disqualification for duty in MOS (Military Occupational Specialty);
- (d) Acceptance into ROTC (Reserve Officer Training Corps) Program; and
- (e) Secretarial authority.

(3) If an Army veteran served less than 21 months and none of the other exceptions listed under subparagraph b or c apply, the individual is not eligible for VA medical benefits.

(4) The minimum period of enlistment in the Navy, Air Force, Marine Corps and Coast Guard is at least 3 years. Therefore, individuals discharged from those branches with less than 24 months service could not have 10 U.S.C. 1171, discharges, since the discharges would have to occur after at least 33 months service to be under 10 U.S.C. 1171.

4.18 HOSPITAL CARE

a. Title 38 CFR, sections 17.45 and 17.47, are the basic authority under which hospital treatment may be provided to persons discharged, released, or retired from active military, naval or air service.

b. Title 38 CFR, section 17.46(b), is the authority for hospital treatment for persons in the active service of the Armed Forces of the United States, pensioners of nations allied with the United States in World Wars I and II, and beneficiaries of other Federal agencies.

c. Title 38 CFR, section 17.46(c), is the authority for furnishing emergency medical and psychiatric hospital treatment to persons other than those in subparagraphs a and b.

d. Title 38 CFR, section 17.45, is the authority for furnishing hospitalization for observation and physical (including mental) examinations.

e. Title 38 CFR, section 17.46(d), is the authority for hospitalization and use of a VA medical resource pursuant to a sharing agreement.

f. Title 38 CFR, section 17.46c, is the authority for hospitalization of non-veterans for approved research purposes.

g. Title 38 CFR, section 17.54(c), is the authority for hospitalization for CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) beneficiaries. Hospital care may be provided in VA medical facilities which are equipped to provide the care and treatment if such facilities are not otherwise being utilized for the care of veterans.

h. Title 38 CFR, section 17.55, is the authority for providing hospitalization and domiciliary care for certain former members of the armed forces of the Government of Czechoslovakia or Poland.

i. Renal dialysis workload will be recorded as an outpatient visit rather than a 1-day admission.

j. Veterans in State home hospitals are not subject to means test for care in the State home; however, these patients are subject to the income based means test when applying for medical care at VA facilities.

4.19 DOMICILIARY CARE

Title 38, CFR, section 17.47, paragraphs (e)(1) and (e)(2), are the applicable provisions under which domiciliary care may be provided to eligible veterans. Veterans in State home domiciliaries are not subject to means test for care in the state home; however, they are subject to the income limitations described in 38 CFR 17.47e. These patients are subject to the income based means test when applying for medical care at VA facilities.

4.20. NURSING HOME CARE

See M-1, part I, chapter 12, for VA Nursing Home Program and M-1, part I, chapter 3, for State Home Nursing Program.

4.21 TRANSPORTATION

For transportation incident to inpatient care see 38 CFR, section 17.100; MP-1, part II, chapter 3; and M-I, part I, chapter 25.

4.22 CERTAIN CONSIDERATIONS IN DETERMINING ELIGIBILITY

In general, eligibility for hospital or domiciliary care will be established under the appropriate paragraph of 38 CFR, section 17.46 or 17.47. Certain special groups who may be considered within the purview of these regulations include:

	Eligible	Not Eligible
Aliens	Discharge from the Armed Forces in World War I of alienage will not in itself bar an applicant from hospital or domiciliary care under 38 CFR 17.47. If an alien was discharged because of the War Department Order of January 27, 1918, which directed that " All subjects of countries with which we are at war do not desire to serve in the United States" be released, this would not of itself invalidate potential entitlement. Individual consideration is to be given such applicants.	
	Applicants who present affirmative evidence that they had not solicited an alienage discharge, and those aliens who requested a discharge after November 11, 1918. (See 38 CFR 3.7 (b))	Discharge before November 1918, is presumed to have been at the alien's request, and the burden of proof is the alien's to show that it was not. The question whether evidence submitted is sufficient to rebut the presumption that the applicant had been discharged at the applicant's own request is one of fact.
Civilian Units Performing Defense Duties		During World War II, various State Guard and Home Guard units were organized to

Civilian Units Performing Duties (Continued)	Eligible	Not Eligible
	Civilian Contractual Personnel	<p>Quartermaster Corps female clerical employees serving with the American Expeditionary Forces. Civilian employees, Pacific Navel Air Bases, who actively participated in the defense of Wake Island. Civilian Personnel assigned to the Secret Intelligence Element of the Office of Strategic Services. Reconstruction Aides and Dietitians, World War I. Wake Island Defenders from Guam. Guam Combat Patrol. Signal Corps Female Telephone Operators Unit of World War I. Engineer Field Clerks. Male Civilian Ferry Pilots. Quartermaster Corps Keswick Crew on Corregidor (World War II) U.S. Civilian Volunteers Who Actively Participated in the Defense of Bataan.</p> <p>These individuals must have been certified (DD Form 214) by the Department of Defense as having served on active duty under honorable conditions.</p>

	Eligible	Not Eligible
Contract Nurses	Women who served as Army nurses under contract.	World War II. Stevedore superintendents who served with the U.S. Army during the period October 1944 to November 1945.
	An applicant who absented from command for a period of permitted leave granted prior to November 11, 1918, and extending beyond the date of cessation of hostilities and did not return because the applicant did not know it was necessary to do so, and no determination as to desertion has been made by the service department.	Applicants that deserted prior to cessation of hostilities in World War I, whether they were or were not dishonorably discharged.
Eligibility Lost by Change of Legislation	Persons properly admitted under laws in effect at time of admission and who because of subsequent legislation are deprived of eligibility may continue in the hospitalization or domiciliary care until such time as they may be discharged there from without jeopardizing their life or limb.	Persons previously eligible under this provision are not eligible for readmission following discharge.

	Eligible	Not Eligible
Members of Training Camps	Members of training camps authorized under section 54, National Defense Act of June 3, 1916 (Pub. L. 85, 64th Cong.), who were enrolled in such camps on or after April 6, 1917, and before November 12, 1918, to obtain a commission upon satisfactory conclusion of such training.	Persons who attended these camps to qualify as instructors in various colleges.
National Guard Mobilized for Civil Disturbances	Mobilization as a result of a Federal order or directive is considered active military service	Mobilization as a result of an order of the chief Executive of a State is not considered active military service.
Paymasters Clerk	Persons who served as paymasters' Clerks of the U.S. Army in the Philippine Insurrection or Boxer Rebellion	
Philippine Army Service Guerrillas and Old and New Philippine Scouts (Apr. 1942 to June 1946)	<p>Old (or Regular) Philippine Scouts (who ENLISTED PRIOR TO OCTOBER 6, 1945, into the Armed Forces of the United States), same eligibility as Veterans of the U.S. Armed Forces.</p> <p>Commonwealth Army Veterans: (7-26-41 to 6-30-46)</p> <p>Recognized Guerrillas: (Apr. 1942 to June 1946).</p> <p>New Philippine Scouts: (10-6-45 to 6-30-47) for hospital and nursing home care and medical services in the United States for treatment of their service-connected or adjunct disabilities only. These individuals are not eligible</p>	

	Eligible	Not Eligible
	<p>for VA care either within the Philippines or outside the Philippines except in U.S. Facilities over which the Secretary has direct jurisdiction and in other government facilities with which the Secretary contracts</p>	
<p>Release for Disability or Dependency Prior to Final Acceptance</p>		<p>Certain National Guardsmen who answered the President's call for World War I and II service and others who having enlisted for Federal Service during these two periods, were, on reporting to camps or stations, physically disqualified or discharged for dependency reasons prior to physical examination and final acceptance into active Federal Service. A discharge from the World War I draft will not be considered as a dishrag from active military service. (In questionable cases, information will be obtained from military department as to whether such applicants were physically examined and finally accepted for Federal Service.)</p>
<p>Reservist</p>	<p>Reservists will meet the definition of active duty if the facts of record establish that the service was full-time and was for operational or support (as opposed to training purposes). Refer to Regional Office for opinion.</p>	<p>Reservists who have performed 6 months active duty for training purposes or inactive duty training, for treatment of a nonservice-connected disease or injury.</p>

	Eligible	Not Eligible
WAAC	Former members- of WAAC Corps)- service between May 13, 1942, and September 30, 1943, prior to establish of Women's Army Corps.	
WASP (Women's Air Forces Service Pilots) or Similar United States groups	Individuals who have been certified (DD Form 214) by the Department of Defense as having served on active duty. Included are members of the WASP (a group of Federal civilian employees attached to the Army Air Force during World War II) or the service of any person in any other similarly situated group, the members of which rendered service to the Armed Forces of the United States in a capacity considered civilian employment or contractual service at the time such service was rendered. Prima facie eligibility for care is not acceptable.	
Active or Inactive Duty for Training with SC (Service connected Disability	Veterans who are disabled from disease or injury incurred or aggravated in line of duty while serving on active or inactive duty for training, and are rated SC for the disability (ies), are eligible for medical care in the same manner as any other veteran who served on active duty.	

	Eligible	Not Eligible
Women-Hospitalization	Women veterans needing treatment for SC and NSC (non-service-connected) diseases or injuries may be hospitalized in accordance with 38 CFR 17.50b (a) (4).	
MERCHANT MARINES	Merchant Marines who served on U.S. flagged merchant ships between December 7, 1941, and August 5, 1945, may be eligible for VA medical care after they have received a DD214.	
U.S. civilian employees of airlines contracted with Air Transport Command during WW II.	Employees of American Airlines; Consolidated Vultee Aircraft Corporation; and, Pan American World Airways who served overseas during the period December 14, 1941, and August 14, 1945.	
U.S. civilians of the American Field Service	Services of U.S. civilians of the AFS (American Field Service) who served overseas operationally in World War I during the period August 31, 1917, to January 1, 1918, and U.S. Army Groups in World War II during the period December 7, 1941, through May 8, 1945, may be eligible for VA medical care after they have received a DD214.	

	Eligible	Not Eligible
Civilian Crewmen of U.S. Coast and Geodetic Survey Vessels	Service of the group known as " Civilian crewmen of United States Coast and Geodetic Survey vessels who served as a crewmen in areas of immediate military hazard while conducting cooperative operations with and for the U.S. Armed Forces between December 7, 1941, and August 15, 1945, aboard the Derickson; Explorer; Gilbert; Hilgard; E. Lester Jones; Lydonia; Patton; Surveyor; Wainwright; or Westdahl; may be eligible for VA medical care.	
Honorably Discharged Members of the AVG (American Volunteer Group/ Flying Tigers)	Who served during period December 7, 1941, in China and those who served with Eritea Service Command during period June 21, 1942, to March 31, 1943. China served as evidenced by an AVG honorable discharge certificate, letter, or identified in other credible publications or documents.	

4.23 VETERANS HELD UNDER CHARGES

a. A veteran in the custody of civil authorities or under criminal charges does not forfeit any right to hospital or domiciliary care by VA. These veterans may be accepted for hospital and domiciliary treatment by VA only when released by an authorized official under circumstances where there is no obligation placed on VA to exercise custodial restraint or assure the return of the veteran to custody upon completion of treatment. This does not preclude advising civil authorities of the expected date of discharge when requested.

b. There is no prohibition against treatment of veterans accompanied by guards. However, medical center Directors may determine, on a case-by-case bases, that barring treatment for these veterans is necessary if the presence of such individuals would be disruptive (behavior problems, etc.) to the process of providing quality medical care.

4.24 PERSONS RETIRED FROM MILITARY SERVICE

a. Persons retired from military service are entitled to hospital and domiciliary care on the same basis as discharged veterans, including hospitalization in VA, other Federal and non-Federal facilities.

b. When a military retiree applies for hospitalization, action will be taken to determine whether the applicant is eligible for the care as a VA beneficiary. If the applicant was released from military service for disability incurred or aggravated in line of duty, or has a SC disability, the applicant is eligible as a Mandatory VA beneficiary. An applicant who was not retired for disability and has no SC disability will first be considered as an applicant seeking care as a VA beneficiary. The application will be processed in the same manner as any application. If the applicant is a means test Discretionary veteran and refuses to agree to make the co-payments, or is not eligible for care as a veteran, then the applicant can be provided care as a beneficiary of DOD only under one of the following conditions:

(1) Under specific MOUs (Memoranda of Understanding). There is presently in effect a VA/DOD MOU for the referral of DOD beneficiaries who require care at VA facilities.

(2) When a DOD patient is referred to a VA facility for specific care by a military MTF (medical treatment facility). This referral must be confirmed in writing by the MTF on a DD 2161, Referral for Civilian Medical Care). It is not sufficient for a retiree to walk into a VA facility and state that the retiree was referred.

(3) When there is a DOD/VA sharing agreement in effect between a VA facility and an MTF stipulating that the MTF will reimburse the VA facility for specific types of care to retirees or dependents who are appropriately referred.

c. Bills for services authorized by DD 2161's should be submitted as soon as the records are complete, but no later than 12 months after the care was provided.

4.25 RESPONSIBILITY FOR DETERMINATION OF ELIGIBILITY AND NEED FOR HOSPITAL OR DOMICILIARY CARE

While overall responsibility for providing hospital and domiciliary care is that of the health care facility Director the specific responsibilities for establishing eligibility and need for hospital or domiciliary care will be delegated as follows:

a. Medical need for hospital or domiciliary care will be determined by a responsible physician of the VA facility assigned this function.

b. Eligibility will be determined by appropriate administrative personnel.

4.26 PRIORITIES FOR HOSPITAL CARE AND NURSING HOME CARE

a. Medical or psychiatric applicants presenting a bona fide medical emergency (i.e., delay in immediate admission would result in a serious threat to life or health) will be admitted immediately without regard to their eligibility under the priority groups listed in subparagraph b.

b. **Priority Groups**

- (1) **Priority I:** Any veteran who has a SC disability currently hospitalized in a VA medical center or a non-VA health care facility at VA expense.
- (2) **Priority II:** Any veteran who has a SC disability.
- (3) **Priority III:** Active duty military members during and immediately following a war or a national emergency, declared by the President or Congress, involving the use of the Armed Forces in armed conflict.
- (4) **Priority IV:** Any veteran whose discharge or release from the active military, naval, or air service, was for a disability incurred or aggravated in line of duty, for any disability.
- (5) **Priority V:** NSC veterans who are hospitalized in a VA medical center or a non-VA health care facility at VA expense who are:
 - (a) Former POWs;
 - (b) Veterans of World War I;
 - (c) The Spanish American War or the Mexican Border Period;
 - (d) Veterans receiving a VA pension;
 - (e) Veterans eligible for Medicaid;
 - (f) Veterans exposed to a toxic substance while serving in Vietnam or exposed to ionizing radiation; and
 - (g) Veterans whose income is below the established level required to make a copayment for care.
- (6) **Priority VI:** NSC veterans in priority V who are not hospitalized.
- (7) **Priority VII:** Armed Forces active duty personnel who are transferred in anticipation of retirement or separation from active service.
- (8) **Priority VIII:** NSC veterans who are hospitalized in a VA medical center or a non-VA health care facility at VA expense whose income exceeds the established level which requires a copayment for care.
- (9) **Priority IX:** All other NSC veterans whose income exceeds the established level which requires a copayment for care.
- (10) **Priority X:** Survivors and dependents of certain veterans (CFR 17.54), beneficiaries of other federal agencies, and persons receiving care under a sharing agreement.

c. Order of Consideration within Priority Groups

- (1) All applications within a priority group will be identified as an "Urgent" or "General" admission, depending upon the examining physician's decisions with respect to medical need for hospital care in each case. Those identified as "Urgent" will be given priority over those identified as "General."

(2) When a suitable bed is vacant and not needed for an emergency admission, the following rule will apply. The bed will be offered to the person for whom it is suitable who is listed in the highest priority group. No person in any priority group, whether in the urgent or general category, will be offered the bed if there are one or more persons for whom it is suitable who are in the urgent or general category of the higher priority group.

4.27 DETERMINATION OF MEDICAL NEED

Medical need is determined by a VA physician on the basis of an examination or on the basis of information furnished on VA Form 10-10m, Medical Certificate. The physician will determine the type of care required, so indicate on the VA Form 10-10m, and sign and date the form. Applicants who need inpatient care for chronic conditions will not be refused acceptance for medical care because of character of illness, non-availability of a bed, education and research interests or other extraneous considerations. All reasonable doubt as to medical need for hospital care will be resolved in favor of the applicant.

4.28 DETERMINATION OF ELIGIBILITY FOR HOSPITAL CARE

The eligibility procedure is divided into two phases:

a. Determination of Eligibility

(1) The determination of eligibility will be made on the basis of information furnished on the application by the applicant, or person acting for the applicant. It requires use of reasonable judgment to reach a decision that the information supplied qualifies the applicant for admission under the appropriate subparagraph of 38 CFR. This judgment will be based on the premise that the information was given with full awareness on the part of the applicant of the penalties for making a fraudulent claim. An inquiry may be made to HINQ (Hospital Inquiry) for identification and file location when making eligibility determinations; however, the admission of applicants with emergent conditions will not be delayed but processed as shown in paragraph 4.32.

(2) Health care facility directors will assure that all interviews of applicants are conducted privately and with the utmost courtesy. No veteran will be expected to furnish information of a personal or confidential nature in public. VA Form 10-10F will be completed in an interview with a VA employee. VA personnel will be guided by the advice of the examining VA physician as to the extent the veteran may be interviewed. If the veteran's condition precludes participating, the required information will be obtained from the veteran's guardian or other person acting for the veteran. VA Form 10-10F should be completed on all appropriate applicants as soon as possible. This should be accomplished only after the applicant has been evaluated by the clinical staff to determine that a medical emergency does not exist.

b. Verification of Eligibility

(1) The information furnished by applicants will be verified when necessary by submission of VA Form 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action (see M-1, pt. I, ch. 6), when data cannot be verified from existing facility records or when the applicant's eligibility for medical care cannot be established by DD Form 214, or equivalent, or by HINQ.

(2) All applicants who are not SC, former POWs, veterans of W.W.I or the Mexican Border period, in receipt of VA pension, participating in VA Vocational Rehabilitation program, eligible for Medicaid, or in need of care for a condition possibly related to either Agent Orange or to ionizing radiation must complete VA Form 10-10F. That requirement applies also to veterans living in State homes who are transferred to the VA for hospital care. Instructions for completion of the form are in appendix 4D. The form is used to determine the veteran's attributable income and net worth. The VA Form 10-10F will be up-dated annually on the visit following the anniversary date of the last VA Form 10-10F.

(3) Effective on January 1 of each year after calendar year 1986, the income threshold amounts for the eligibility categories for NSC veterans are increased by the percentage by which the maximum rates of pension are increased for the year. MAS (161B), VA Central Office, will notify field facilities of the changes.

(4) After medical need for hospital care has been established by the examining physician, Medical Administration personnel will determine which subparagraph of 38 CFR is appropriate as the admission authority and complete the eligibility block on the application. The patient will not be admitted until eligibility can be verified when admission is for an elective procedure or for care that can reasonably be delayed without endangering the patient's life.

4.29 NET WORTH DEVELOPMENT

a. When a NSC veteran's income places the veteran in "mandatory" or "discretionary" care categories and the income plus net worth is less than or equal to \$50,000, the determination of the veteran's eligibility category will be based on the veteran's income alone (excluding SSI (supplemental security income). Example: A veteran with no dependents whose income is \$12,000 and whose net worth is \$20,000 (income plus assets = \$32,000) will be determined to be a mandatory veteran for medical care.

b. When a NSC veteran's income alone places the veteran in the mandatory category, but income plus net worth is greater than \$50,000, further development will be undertaken and the veteran tentatively placed in the discretionary category. VA Form 10-7131, with the following statement in Item 6, "Net worth determination for medical care;" a completed VA Form 21-8049, Request for Details of Expenses, and a copy of the completed VA Form 10-10F should be forwarded to the appropriate regional office for a determination whether the veteran's net worth places the veteran in the Discretionary category.

c. When a farmer, rancher or small business owner (including persons owning or in possession of income producing property) applies for medical care, the VA Form 10-10F, Financial Worksheet, will be reviewed to determine if the veteran's income plus net worth is less than or equal to \$50,000. If so, the determination of the veteran's eligibility category will be based on the veteran's income alone. If the review determines that the veteran's income plus net worth is greater than \$50,000, further development of the application for care is required. The veteran will be advised that a net worth determination will be forwarded to the appropriate Regional Office and the veteran must agree to pay the applicable deductibles for the medical care provided by the treating facility. The veteran will be tentatively placed in the discretionary category. A package will be prepared and sent to the Regional Office for a determination of whether the net worth places the veteran in discretionary. The

package will contain either VA Form 21-4185, Report of Income from Property or Business, or VA Form 21-4165, Pension Claim Questionnaire for Farm Income; a completed VA Form 21-8049; a copy of the completed VA Form 10-10F; and VA Form 10-7131 with the following statement in Item 6, "Net worth determination for medical care." The veteran may also submit other information for the regional office to have in making a determination, such as land appraisals, statements from real estate brokers concerning the value of property in the area, etc.

d. For veterans who reapply for medical care, net worth determinations are valid for 1 year unless the veteran's income or net worth changes significantly. (See par. 4.30).

e. VA Form 21-8049, Request for Details of Expenses, will be returned by the VA Regional Office Adjudication Division, with a conclusion indicated in Item 13. When the determination is that "net worth is not a bar," medical care may be provided without copayment and the veteran will be placed in the appropriate eligibility category according to income. When the determination is that "net worth is a bar," the veteran will remain in the discretionary category. An automated file should be used to track the Regional Office response time. If an automated system is not available, a manual system should be initiated. If a response has not been received from the Regional Office within 4 weeks, the Chief, MAS, should contact the Adjudication Officer to inquire about the status of the request.

4.30 HARDSHIP

a. To avoid hardship, a veteran may be placed in the mandatory category even though the veteran's income is not within the mandatory income limits. Such a determination may be made when clear and convincing evidence indicates that the veteran's projected income for the year following the application for care is substantially below the income for the year preceding the application and below the mandatory income threshold.

b. The determination of eligibility based on hardship must be approved by the Director of the health care facility or written designee. The circumstances to be considered, the current yearly projected income, and the adjusted eligibility category should be documented on VA Form 119, and filed in the veteran's medical record. No change will be made in the previous calendar year's income data on VA Form 10-10F.

c. Circumstances that would warrant hardship consideration would be loss of employment, business bankruptcy and serious illness. Residence in an area of a high cost of living would not constitute grounds for approval of an income adjustment. Consideration of income changes from the last calendar year should only be made in rare and exceptional circumstances.

d. The VA Form 10-10F will be updated 1 year after the date the hardship is approved and annually thereafter.

4.31 DISCRETIONARY VETERANS--COPAYMENT FOR VA CARE

a. To receive care a NSC veteran who exceeds the Mandatory income threshold amounts must sign the appropriate block on VA Form 10-10F agreeing to pay a copayment for the care rendered by the VA health care facility. (See app. 4E.)

b. Veterans eligible for HISA (Home Improvements and Structural Alterations) do not make co-payments for approved HISA benefits.

c. NSC veterans who were receiving hospital care or nursing home care from the VA on June 30, 1986, will not be obligated to pay or agree to pay copayment until a new episode of care begins. The episode of hospital or nursing home care in effect on June 30, 1986, is defined as ending on the day of the veteran's discharge from inpatient status of the medical center or nursing home facility. A period of ASIH (absent sick in hospital) is considered a new episode of care.

4.32 CLASSIFICATION OF PATIENTS

a. The term "emergency," when used in connection with an application for hospitalization, indicates a medical classification of the applicant regardless of VA regulation cited as the admission authority. This classification by the examining physician calls for the immediate admission of the medical or psychiatric applicant. Emergency medical or psychiatric applicants are referred without delay, to the examining physician. The examining physician determines whether an admission interview is permitted and if so, to what extent the patient may be questioned.

b. The term "urgent" describes a condition which does not necessitate immediate admission, but one for which there is pressing need for hospitalization to prevent deterioration of the condition or impairment of the possibilities of recovery. It suggests that the longer hospitalization is delayed the more serious the probable consequences will be for the patient, and the more difficult it will be to arrest, reverse, or care for the condition.

c. The term "general" describes a condition which at the time of the examination was found to be neither "emergent" nor "urgent."

d. Directors of health care facilities will establish procedures whereby applicants for medical or psychiatric problems are medically screened to determine if their need for care appears to be emergent or urgent. Those in need of emergent care will be examined promptly and furnished necessary medical care. The determination of their ability to pay will be made after the initial examination and essential treatment. Applicable co-payments will be determined and billed to the veteran for the care rendered by the facility, if appropriate.

4.33 ADMISSION AUTHORITIES--EMERGENCY PATIENTS

Title 38 CFR, section 17.35 will be cited as the admission authority only for medical or psychiatric applicants who cannot with reasonable certainty be admitted under 38 CFR 17.45, 17.46 or 17.47. When the appropriate admission authority is determined, it will be changed accordingly.

4.34 TELEPHONIC REQUESTS FOR ADMISSION

a. The determination of eligibility on telephonic requests for hospitalization must, out of necessity, be based on the information supplied by the caller. The information may be very limited. Patients may be accepted for admission based on information relayed by phone. Such patients usually require emergency medical or psychiatric care. When these patients arrive at the facility, they will be processed as outlined in paragraph 4.28.

b. When the telephone request is not for an emergency admission or the admission is not otherwise authorized, the caller will be requested to submit a written application. All telephone requests should be considered as a valid request to apply for medical benefits and employees will offer assistance to the caller in submitting an application. Employees will offer to mail to the caller the appropriate application forms. When the completed application forms are received by the VA facility, determination of medical need will be made by a VA physician based on information furnished on VA Form 10-10m, or other documentation submitted with the application, or the veteran will be scheduled for examination.

c. Under no circumstances will admission be denied based on circumstances described by a caller in a telephone contact. Application forms should be sent to the caller in all cases so the veteran has an opportunity to apply for care and the veteran's eligibility can be determined by the facts documented on the application form. An examination to determine medical need may be scheduled based on the initial telephone contact.

d. Mailed-in applications, scheduled admissions and scheduled examinations will be processed using appropriate registration and scheduling functions in DHCP. The DHCP system tabulates application counts for AMIS (Automated Management Information System) reports from these functions.

4.35 DETERMINATION AND VERIFICATION OF ELIGIBILITY FOR DOMICILIARY CARE

The determination and verification of eligibility for domiciliary care will be made in the same manner as that prescribed for hospital admission. Admission or placement on the waiting list will be delayed pending verification of legal eligibility on VA Form 10-7131 when such admission will not be dangerous to the patient.

4.36 HOSPITAL AND NURSING HOME CARE AND MEDICAL SERVICES IN THE UNITED STATES FOR CERTAIN PHILIPPINE BENEFICIARIES

New Philippine Scouts and Commonwealth Army veterans are only eligible for hospital and nursing home care and medical services for treatment of their SC or adjunct disabilities within the limits of VA facilities in the United States. These veterans and scouts may receive such care in a facility over which the Secretary has direct jurisdiction and in other Government facilities with which the Secretary contracts.

4.37 PERSONS GRANTED UPGRADED DISCHARGES

a. Veterans who receive "honorable" or "general (under honorable conditions)" discharges at the time of separation from active duty shall be furnished medical benefits without the Regional Office discharge review.

b. Veterans with discharges upgraded from "other than honorable" to "general", issued through a Board for Correction of Military Records established under authority of 10 U.S.C. 1551, shall not be furnished medical benefits based on such upgrading alone. In this instance, follow the instructions contained in M-1, part I, chapter 6, on the completion of VA Form 10-7131, and submit it to the Regional Office under the special discharge review program.

4.38 APPLICANTS WITH OTHER THAN HONORABLE DISCHARGES

a. Discharges characterized by the service departments as "other than honorable" may or may not qualify an individual for VA medical benefits. A special determination

must be made by the Adjudication Division of the appropriate Regional Office, based on the facts of each case, whether the discharge is a bar to VA benefits. Upon receipt of an application from a veteran with an "other than honorable" discharge, a VA Form 10-7131 will be initiated.

b. In some cases, persons discharged or released from active duty under other than honorable conditions may only be provided medical benefits for service-incurred or aggravated line of duty disabilities, if:

- (1) The injury did not occur outside the line of duty and
- (2) Was not due to the person's own willful misconduct, and
- (3) Release was not under a "bad conduct" discharge or for a cause that is a bar to VA benefits.

(a) These applicants will not be provided medical benefits until the following specific information is obtained:

- (1) Identity of disabilities incurred or aggravated in line of duty.
- (2) Character of discharge or conditional release that terminated the period of service in which disability was incurred or aggravated.
- (3) Determination of whether a statutory bar to VA benefits exists.

(b) After it has been determined that persons identified in subparagraph b are eligible for care, the following should be accomplished:

(1) Flag the DHCP VA Form 10-10 under remarks: "CARE MAY BE PROVIDED FOR SC DISABILITIES ONLY."

(2) Flag CHR to show "CARE MAY BE PROVIDED FOR THE FOLLOWING DISABILITIES ONLY." List disabilities incurred in or aggravated in line of duty.

(3) Provide care for the disabilities incurred or aggravated in line of duty.

(4) Provide care for conditions adjunct to the disabilities incurred or aggravated in line of duty.

(c) Care should not be provided for disabilities other than those incurred or aggravated in line of duty or conditions adjunct thereto. In those rare instances where it becomes necessary to provide other care, the following must be accomplished:

(1) The patient will be advised of the fact that the patient will be billed for such care.

(2) Bill for collection will be prepared in accordance with the provisions of M-1, part I, chapter 15. Controls should be established to ensure that the patient is billed only for that care provided for which legal entitlement to VA treatment does not exist.

SECTION III. POLICY AND PROCEDURE FOR MANAGEMENT AND CONTROL OF WAITING LISTS

4.39 GENERAL

The purpose of maintaining waiting lists for VA facilities is to keep an active roster of patients requiring admission to facilities. Waiting lists will not be used as a device to

delay a decision based on professional judgment. It is expected that every patient placed on a waiting list will be admitted to a VA facility, unless the patient's need for treatment by VA ceases prior to the scheduled reporting date.

4.40 RESPONSIBILITIES OF HEALTH CARE FACILITY DIRECTORS

a. Health care facility Directors will arrange for a continuing review of their waiting lists to ensure that applications are accurately maintained and reflect present demand for care.

b. Health care facility Directors will coordinate interfacility transfer of waiting list applications when it is evident that timely admission cannot be offered at the point of application. This includes determining that another facility can offer admission to an appropriate bed at an earlier date, and that the arrangement is acceptable to the concerned applicants or their representatives. Transferred applications will be the oldest ones with the highest admission priority within the particular bed service or section involved.

4.41 WAITING LIST FILE

a. Applications for hospital care involving medical emergencies, from veterans requiring care for SC disabilities will be processed as currently prescribed. Accordingly, it is expected there will be no occasions when these applications will be placed on a waiting list.

b. Applications will be processed in accordance with priorities in paragraph 4.26 and as follows:

(1) Admission will be offered when a suitable bed is available.

(2) If a suitable bed is not available, but will be within 15 calendar days, admission will be scheduled. The applicant will be placed in PBC when appropriate.

(3) Applicants on the waiting list or to be placed on the waiting list who require admission earlier than can reasonably be expected at an appropriate VA facility, will be tactfully advised on the true prospects for their admission. If the applicant is incompetent, this information will be given to the next of kin or other representative. At least two other facilities with appropriate treatment capabilities, beginning with the one nearest the patient's residence, will be contacted by telephone and requested to accept the application. If none of the facilities contacted can do this, the application will be placed on the waiting list. If the veteran is admitted to a non-VA hospital, the application will remain on the waiting list unless withdrawn by the veteran or a representative or it is otherwise determined at a later date that hospitalization is no longer required.

(4) If the facility first receiving the application is not staffed and equipped to provide the care the applicant requires, the application will be forwarded to the facility nearest the patient's home which has necessary treatment capabilities. The facility receiving the application by transfer will take the action prescribed in subparagraph b. (1) through (3).

c. The waiting list file will be established by the priorities contained in paragraph 4.26. Within each priority group the applications will be classified by services and

sections, as necessary, to conform with beds operated at the facility. They will be filed in date sequence within each grouping, with the oldest application in front. The date of receipt of the application by VA will be used to determine the oldest application. Each file group (service and section) will be further divided to permit separate filing and identification of applications classified as "urgent" and "general." All veterans in the mandatory category will be admitted before discretionary category veterans.

4.42 MAINTENANCE OF WAITING LIST

a. The waiting list will be kept current and will be readily accessible at all times to concerned professional and administrative personnel.

b. An applicant who remains on the waiting list for 30 calendar days will be called in as soon as possible for a reexamination to determine possible changes in the condition, and reclassification when appropriate. When a staff examination at a VA facility is not feasible, because of distance or other cogent reason, the applicant will be requested to have a physician submit the results of a reevaluation.

c. An applicant for medical or psychiatric care who is classified as "emergent" as a result of the reevaluation will be admitted. When the applicant is classified in the "urgent" category and a suitable bed is not available within the region, the Regional Director will be requested to furnish assistance in obtaining a bed.

d. Mandatory veterans who are classified in the "general" category as a result of reevaluation will be removed from the waiting list. A concerted effort will be made to find these veterans beds within the VA system. Discretionary veterans who are classified in the "general" category but cannot be scheduled for admission within the VA system will remain on the waiting list until admitted. Selection of patients from the waiting list is made according to priorities and earliest date of application.

e. When the reexamination discloses that hospitalization is no longer indicated, or the patient fails to report for the examination, or submit a report of reexamination within 15 calendar days, the application will be canceled.

4.43 ADMISSION FROM WAITING LIST

When a bed is available, the following rule will apply: the bed will be offered to the person for whom it is suitable who is listed first in the highest priority group.

SECTION IV. POLICY AND PROCEDURE FOR TRANSFERRING INSERVICE PATIENTS FROM MILITARY HOSPITALS TO VA

4.44 GENERAL

a. VA will admit to its facilities certain military patients who have not been discharged from service, when they have potential eligibility as VA beneficiaries.

b. Military patients will not be hospitalized as VA beneficiaries in other Federal hospitals.

c. The term "military" as used in this section includes all branches of the Armed Forces.

4.45 SCREENING BY MILITARY HOSPITAL

If, subsequent to the admission of the patient to a VA facility, information is received that the planned type of discharge is to be changed to a discharge under dishonorable conditions, the appropriate military administrative facility will be advised that the patient is to be returned to direct military care prior to the effective date of discharge. See subparagraph 4.52b. for exceptions.

4.46 ADMINISTRATIVE RESPONSIBILITY FOR BED DESIGNATION AND TRANSFER PROCEDURES

a. Arrangements for reservation of beds to accommodate military patients in appropriate VA facilities are made between ASMRO and the VA facility concerned. Facility replies to requests for bed reservations for military patients will be given top priority. Under no circumstances will a bed reservation be refused because the patient's condition might require prolonged care. Each teletype message to the ASMRO advising of the availability of a bed will be prepared and transmitted to ASMRO within 1 workday following receipt of the ASMRO request for a bed reservation. The teletype acceptance of the patient will also include the name of the physician (e.g., chief of service/section, or appropriate designee) to be contacted in the event the military hospital physician concerned wishes to discuss the case prior to the patient's movement. The teletype acceptance will not stipulate that the military patient must arrive at the VA facility before a certain hour (e.g., before 11 a.m.).

b. When notified by ASMRO that a bed has been reserved in a particular VA facility, the military hospital having the patient will arrange for the transfer and advise the designated VA facility of the expected date and time of the patient's arrival. Normally, there should be no more than 15 days between the day a bed reservation is established and the day the patient arrives at the VA facility. In exceptional cases, the bed reservation will be held for a maximum of 30 days.

c. If the military patient does not arrive within this period, the VA facility may cancel the bed reservation and notify the ASMRO, Scott Air Force Base, IL 62225-5000.

4.47 TRANSFER OF SPECIAL CATEGORY PATIENTS

a. The military hospital with a SCI, TBI (Traumatic Brain Injury), or BR (Blind Rehabilitation) patient will notify the ASMRO of the patient's need for transfer. The ASMRO will determine which VA health care facility with a VA Central Office approved program/service is the appropriate facility to receive the patient.

b. The appropriate medical and administrative personnel of the military hospital will establish immediate personal phone contact with their counterparts at the designated VA health care facility to discuss and make arrangements for each case. Should telephone communications from outside the continental United States be difficult with the receiving VA health care facility, the referring military hospital is authorized to proceed with the patient's transfer after sending a telegram to the receiving VA health care facility.

c. A "Memorandum of Understanding" between VA and DOD has been approved with the objective of providing the most expeditious and best possible care for active duty military personnel who sustain SCIs, TBIs or required blind rehabilitation. The general goal is to effect transfer within 3 days (4 days from overseas) and in no instance to exceed 12 days, post injury for transfer. The ability to complete Medical Review Board processing is not a prerequisite for these transfers.

d. When the patient is ready for transfer, transfer will be effected immediately to the appropriate VA health care facility without regard to holidays or weekends. The Surgeon General's Office of the military service concerned will provide a 24-hour point of contact should problems arise.

e. The Surgeon General's Office of the appropriate military service will provide necessary assistance to VA health care facilities in preparing Medical Review Boards.

4.48 CONTINUED MILITARY JURISDICTION DURING PATIENT'S STAY IN VA FACILITY

a. Military patients in VA facilities remain in military status and are subject to the administrative control of the responsible department. Problems concerning discharge from military service, change of patient's status, temporary hospitalization of patients on furlough or leave, etc., will not be referred to the ASMRO.

b. Army and Air Force patients are under the administrative control of the military hospital from which transferred.

c. Navy patients are under the administrative control of the Commandant of the naval district in which the VA facility is located.

d. Coast Guard patients are under the administrative control of the District Commander of the Coast Guard district in which the VA facility is located.

e. The Army or Air Force hospital, the Commandant of the naval district, or the Coast Guard District Commander, as applicable, will be contacted prior to taking any action which may change the patient's status, except that the VA health care facility Director may authorize convalescent leave for military patients. In such instances, the military facility or organizational element exercising administrative control over the patient will be notified.

4.49 DETERMINATION OF ELIGIBILITY AS VA BENEFICIARY

VA facilities will determine a military patient's eligibility for continued hospitalization as a VA beneficiary on receipt of notification of the patient's separation from military service. The patient's status on the rolls of the facility will be changed to that of a veteran in accordance with existing instructions.

4.50 BILLINGS FOR SERVICES RENDERED TO MILITARY PATIENTS

Reimbursement for hospitalization rendered to military patients will be secured from the appropriate department on the basis of the current per diem interagency reimbursement rate or approved sharing agreement rate in accordance with billing procedures in M-1, part I, chapter 15.

4.51 PROCESSING COMPENSATION REQUESTS FOR ACTIVE DUTY PATIENTS PENDING RELEASE FROM SERVICE

a. VA Form 21-526e, Veteran's Application for Compensation or Pension at Separation From Service, is to be completed by the veterans benefits counselor for active service patients who are scheduled for separation from service due to disability. These patients are generally ASMRO transfers to VA facilities. The form is completed by the veterans benefits counselor prior to issuance by the military of the DOD DD Form 214.

b. VA Form 21-526e, is to be held in the patient's CHR, administrative portion, pending official notification of release from the service.

c. After receipt of the official discharge from the service, the VA Form 21-526e, a copy of the patient's military health record (if available) and a copy of that portion of the VA health record created prior to the date of issuance of the DD Form 214, will be forwarded to the Adjudication Division of the appropriate regional office of jurisdiction by MAS personnel assigned such responsibility.

d. In those instances where the patient is not discharged from active duty but returns to service, the forms shall be discarded.

4.52 TRANSFER OF ACTIVE DUTY MILITARY PERSONNEL TO VA TO RECEIVE CARE FOR ALCOHOL OR DRUG DEPENDENCE OR ABUSE

a. Title 38 U.S.C. 1720 A subsection (d), provides authority for VA to furnish care or treatment and rehabilitation service for alcohol and drug dependence or abuse disability to any person serving in the active military, naval or air service, providing the active duty member requests transfer to VA during the last 30 days of the member's enlistment period or tour of duty. The request must be in writing, and for a specified period of time during that person's last 30 days of active duty. The time period for such medical care may be extended if the person requests an extension, but only if that person qualifies as a veteran eligible for VA medical care after discharge or release from active duty.

b. Transfer for such care will be coordinated through ASMRO and the transfer request shall specify the period of time for which such care was requested by the active duty member. The referring branch of service agrees to reimburse VA for such care provided during that period of time. Unlike other ASMRO referrals, these referrals may include active duty members who may not or will not receive discharges or releases from service entitling them to veterans benefits.

c. Acceptance of these referred members for up to 30 days of drug or alcohol dependence medical care will not be denied solely because such members will receive an "other than honorable" or "dishonorable" discharge or because such member failed to serve 2 years of an original enlistment or obligated period of service.

d. Admission authorities are 38 CFR 17.46(b)(1), for members of the Armed Forces; and 38 CFR 17.46(b)(2), for commissioned officers of the Public Health Service or National Oceanic and Atmospheric Administration.

e. Billing will be at the current rate for the treatment unit or bed service providing the care as appropriate and/or the current interagency outpatient visit rate for outpatient care.

f. Under no circumstances will such persons be retained in the alcohol or drug dependence treatment program beyond the date of their discharge or release from active duty unless their character of discharge and period of service qualify them for VA medical care as eligible veterans.

SECTION V. ADMISSION SCREENING PROCEDURES

4.53 GENERAL

a. MAS personnel are responsible for obtaining information during an admission screening to assist veterans benefits counselors in providing information and help in connection with VA and other benefits.

b. A few brief questions by admitting personnel of applicants admitted to the facility can almost invariably reveal whether later interview by a veterans benefits counselor is necessary. The questions to be considered and resolved by designated MAS employees are:

(1) Does the veteran have Government life insurance (VGLI (Veterans Group Life Insurance), NSLI (National Service Life Insurance), or USGLI (U.S. Government Life Insurance)), or has such a policy lapsed in the past 12 months?

(2) Does the veteran receive Social Security benefits or have potential entitlement to Social Security benefits?

(3) If receiving compensation or pension, does the veteran wish to continue having the check sent to the present mailing address?

4.54 PREPARATION OF VA FORM 10-1225, VETERANS ASSISTANCE UNIT RECORD

a. VA Form 10-1225, Veterans Assistance Unit Record, will be generated by DHCP for each admission. This form will be either forwarded to the Veterans Benefits Administration Veterans Service Office (27) at the Regional Office having jurisdiction of the area in which the facility is located or will be held for or delivered to the veterans benefits counselor assigned to the facility, as requested by the Regional Office.

b. If the veteran has VGLI, NSLI or USGLI in force or if the insurance has lapsed in the past year, the veterans benefits counselor would desire to discuss the matter with the veteran or to take other appropriate action. The form should be marked to indicate status of Government life insurance.

c. The blocks for "Suggest Contact Interview" or "No Information Obtained" may be checked, if appropriate, by MAS employees, with a brief notation of the reason. In no instance will a patient's admission be deferred if the patient is too ill to discuss the subjects during a screening interview. If for this, or any other reason, the interview is not completed, "No Information Obtained" should be checked.

4.55 VA FORM 572, REQUEST FOR CHANGE OF ADDRESS

If the veteran is receiving pension or compensation from VA, when appropriate, VA Form 572, may be completed and signed by the veteran at time of admission. (In most general medical and surgical cases, or other short-term admissions, the veteran will probably desire to have the check continue to be sent to a home address.) The veterans benefits counselor will provide detailed instructions for the completion and disposition of this form.

4.56 REMINDER TO VETERANS

a. Each patient admitted to the facility will be given a copy of VA Form 10-1225a, Veterans Benefits Information, reminding the veteran that veterans benefits counseling is available on request. A copy of this form will be prominently displayed on bulletin boards in patient areas.

b. Arrangements will be made at the local level to schedule interviews for patients who wish to see a veterans benefits counselor. Due to distances involved, the schedule of service to be provided, availability of FTS, etc., these arrangements will vary from

facility to facility. The agreement reached will be made known to all facility personnel who may receive and channel such requests.

4.57 PATIENT'S RIGHTS AND RESPONSIBILITIES

Each person who is admitted for inpatient care will be given a VA Form 10-7991a, Information Booklet on Patient's Rights and Responsibilities.

4.58 LIAISON OFFICIAL FOR VA BENEFITS

a. Former POWs and individuals who had been designated as missing in action have not always had access to information about veterans benefits or have not always fully comprehended the information furnished. Accordingly, they will be given personalized services and their entitlement to the various benefits will be fully explained to them.

b. The health care facility Director is personally responsible for this function and will appoint a member of the facility staff as the liaison official for VA benefits. This liaison official will be knowledgeable in all types of VA benefits and will work in close relationship with the veterans benefits counselor at the facility and other Veterans Benefits Administration employees located at the appropriate VA Regional Office.

SECTION VI. ELIGIBILITY FOR THE PATIENT ASSISTANCE PROGRAM

4.59 ELIGIBILITY CRITERIA FOR THE PATIENT ASSISTANCE PROGRAM

a. The term PAP (Patient Assistance Program) relates to the gratuitous furnishing of clothing, supplies and services to eligible patients. The Chief, MAS, will determine eligibility for PAP and the Chief, Environmental Management Service, is responsible for all other functions.

b. A patient without means who is receiving monthly income from any source in an amount which is less than the monthly reduced pension rate for domiciliary patients plus \$1 will be eligible for PAP. A patient who has funds or assets which may be liquidated, e.g., bonds, negotiable securities (checks, drafts, etc.) is not without means. Patients who have adequate funds in the custody of guardians, moneys in trust funds (such as personal funds of patients or funds due incompetent beneficiaries) or elsewhere, are not eligible for supplies or services at VA expense. Regular gifts of funds from guardians, relatives, or others will be taken into consideration in determining eligibility, but occasional gifts will not necessitate a predetermination of eligibility.

c. A patient who is in receipt of more monthly income than defined in subparagraph b will be eligible for PAP if the patient is contributing any portion of it to dependents, as defined in 38 CFR 3.50 through 3.59, so as to reduce monthly income for personal use to less than the amount defined in subparagraph b.

d. Funds in excess of \$100 regardless of the source, which may accumulate to the credit of a beneficiary whose income is less than the amount defined in subparagraph b will be applied to the purchase of clothing, clothing services, incidentals, and grooming services as needed.

e. Regardless of the means, amount or source of monthly income, a patient may be temporarily eligible for PAP because of unavailability of funds or until funds become available in the Fiscal Service for withdrawal and/or disbursement. Clothing may be issued and grooming services may be provided only for clearly determined health and sanitary reasons.

f. Patients admitted for observation and examination, patients referred to the facility for brief diagnostic or therapeutic procedures, and in general, patients admitted for brief periods of hospital treatment will not be eligible for clothing or clothing services at VA expense, except for clearly determined health or sanitary reasons. These patients may be furnished incidentals and services at VA expense if they are otherwise eligible.

4.60 DETERMINATION OF ELIGIBILITY

a. The designee of the Chief, MAS, will identify patients eligible for PAP at the time of admission when practical. Eligibility will be based on information which the patient provides, that which is available on VA Form 10-10 and 10-10F in the patient's administrative record, and information as to the amount of funds and other negotiable assets in the patient's possession. The designee of the Chief, Environmental Management Service, will be notified by use of an appropriate overprinted OF 41, Routing and Transmittal Slip, when a beneficiary is admitted who is temporarily or permanently eligible for PAP. The names of eligible patients will be entered daily on a data sheet, VA Form 7051b, Data Sheet, or into a DHCP application if available, for control purposes and to identify such patients for follow-up purposes. VA Forms 7051b and OF-41, will be disposed of in accordance with VHA Records Control Schedule 10-1. Subsequent information received affecting entitlement will be sent by the Chief, MAS, to the designated Environmental Management Service employee. Notification of Environmental Management Service may not be necessary when the Chief, MAS, has been assigned functions of PAP as provided in paragraph 4.82. Information regarding PAP, its eligibility provisions and the name of the designated employee(s) to be contacted in case of need will be made available to patients.

b. The Chief, Domiciliary Operations, will determine eligibility for PAP at facilities which do not have a Chief, MAS, or where this responsibility is delegated to the Chief of Domiciliary Operations.

4.61 PATIENTS IN NON-VA HOSPITALS AT VA EXPENSE

Patients receiving hospital treatment in non-VA hospitals at VA expense may be eligible for PAP.

4.62 REQUESTING FUNDS FOR CLOTHING, INCIDENTALS AND SERVICES

The Chief, MAS, will contact the patient's responsible representative for the purpose of obtaining funds for clothing, incidentals and services when requested by the Chief, Environmental Management Service. FL (Form Letter) 10-93 may be used for this purpose.

4.63 OCCASIONAL PERFORMANCE OF CLOTHING AND VALUABLES FUNCTION BY MEDICAL ADMINISTRATION SERVICE PERSONNEL

The designee of the Chief, MAS, may be required to assume the functions of receipt, storage and release of clothing and valuables during other than regular duty hours when a designee of the Chief, Environmental Management Service is not on duty.

4.64 BARBER OR BEAUTICIAN SERVICES AND INCIDENTALS AT VA EXPENSE

The Chief, MAS, may be assigned the responsibility for procuring grooming services and incidentals for patients eligible for PAP in accordance with M-1, part VII, chapter 9, sections V and VI.

PROCESSING VA FORM 10-10, APPLICATION FOR MEDICAL BENEFITS

4A.01 GENERAL

Entries on VA Form 10-10 should be by pen or typewriter. The computer-generated 10-10 may be used in place of the VA Form 10-10. Except for the admission date and/or authority for admission or treatment, no additional information will be entered on the application, after it is signed by the applicant. Words and phrases such as "verbally" or "orally" next to the character of discharge will not be used.

4A.02 FIRST APPLICATION AT FACILITY

a. An applicant who has never been a patient at the facility where applying for hospitalization or domiciliary care will complete the DHCP registration process. If the VA Form 10-10 is mailed in or manually filled out, the data will be transcribed into the DHCP (Decentralized Hospital Computer Program) registration module. A VA Form 10-10i, Insurance Information, the attachment to computer-generated VA Form 10-10 and the VA Form 10-10F, Financial Worksheet, when applicable, will be completed by all NSC (nonservice-connected) applicants and SC (service-connected) applicants applying for care of NSC conditions.

b. The applicant's name and social security number will be recorded on the bottom of VA Form 10-10m, Medical Certificate, and the applicant will be referred immediately to the examination unit.

c. When it is medically determined that the applicant does not require hospitalization, the examining physician will so inform the applicant in a tactful and explanatory manner. If other VA (Department of Veterans Affairs) supportive care is indicated, the veteran will be referred for immediate attention. If not, no further data will be obtained on VA Form 10-10. If the applicant has been referred to VA by a private physician, the examining VA physician will telephone the physician explaining reasons for not admitting the applicant and what action, if any, VA recommends.

d. As soon as it becomes evident or is determined that an applicant is to be admitted to care, admission office personnel will immediately complete the application and accomplish other needed administrative actions. The Chief, MAS, will establish necessary controls to insure that patients are not lost in the system, and are processed as expeditiously as possible. Admission office personnel should always be alert as to the status of the applicant in the processing cycle and utilize any waiting time available during the professional processing to accomplish the administrative functions. The comfort and welfare of the veterans are paramount, and in no case will administrative processing take precedent over these factors.

4A.03 REAPPLICATION TO SAME FACILITY

a. The registration data elements will be updated in the computer and a new VA Form 10-10 will be generated. The applicant's name and Social Security Number will be recorded on the bottom of VA Form 10-10m, and the applicant will be referred immediately with previous medical records to the examining unit. If the prior medical records are not readily available, the referral will not be delayed. Such records will be obtained at the earliest possible time.

b. When it is determined that an applicant does not require hospitalization, the action as described in paragraph 4A.02c. will be taken.

c. The same procedure outlined in paragraph 4A.02d should be followed if it is determined that the applicant is to be admitted to care.

4A.04 PROCESSING INSTRUCTIONS

When a patient is being readmitted, any changes to the information on the previous application will be recorded in DHCP. Even though no changes are indicated, all patients being readmitted must sign the computer-generated VA Form 10-10.

4A.05 INSTRUCTIONS FOR COMPLETING VA Form 10-10

Most of the items on the VA Form 10-10 are self-explanatory. However, the following definitions and instructions are provided for clarification:

a. All shaded items noted on the hard copy VA Form 10-10 will be completed by VA staff and not by the applicant.

b. Part I, item 18, SCI (Spinal Cord Injury): A spinal cord patient may be defined as a person who has incurred trauma or disease of the spinal cord or cauda equina which has resulted in paraplegia or quadriplegia.

c. Part II, item 1A, First Next of Kin: The person designated first next of kin who is 21 years or older unless applicable State laws allow this designation for persons of lesser age. State laws vary in the finer points of descendency and directors should obtain more precise definitions from the District Counsel serving the medical center. When existent, the laws on descendency for the State where the medical center is located will be used. In the absence of applicable State laws, the term next of kin is defined as follows:

- (1) Surviving spouse;
- (2) Adult children (21 years of age or older, older children having the preference);
- (3) Parents, including adopted parents, stepparents, and foster parents;
- (4) Adult sibling (21 years of age or older) according to age;
- (5) Uncles or aunts;
- (6) Nephews or nieces; and
- (7) Others, i.e., cousins, grandparents, etc. **NOTE:** *In-laws are not included.*

d. Part II, item 2A, Second Next of Kin: Enter the name of the person designated second next of kin.

e. Part II, item 3A, First Contact In An Emergency: Enter the name of the person designated by the applicant or guardian, to be notified in the event of serious illness or death. It should be noted that the emergency addressee may be an intermediary only, and that authority for disposition of remains is vested in the next of kin.

f. Part II, item 4A, Second Contact In An Emergency: Enter the name of the person designated as second contact in an emergency.

g. Part II, item 5A, Designee: Enter the name of the individual who will receive the applicant's personal property. This item will be completed and may be an individual not identified in blocks 1-4.

h. Part V, item 7, Primary Eligibility Code: Enter the eligibility code determined to provide the highest level of medical benefit. For example, if the patient is SC and receives a VA pension as a greater monetary benefit, the primary eligibility code must indicate that the patient is service connected.

i. Part V, item 8, Other Eligibility Code: Enter any other eligibility code determined to provide a lesser level of medical benefit.

j. Part V, item 11m, Dental Injury (Specify teeth extracted): This item will be completed only if the patient is applying for dental care. When applicable, the number of teeth which were extracted during military service will be entered in the space following the item descriptor.

k. Part VI, Income Screening Data or Annual Income

(1) All veterans who require a means test will be income screened. Income screening may also be reported for other veterans whose care is considered discretionary. This latter group of veterans include former POWs (Prisoners of War), and SC veterans rated less than 30 percent who require care for a NSC condition. This information can then be used to determine the appropriate or highest level of eligibility for these veterans.

(2) In order to assess a patient's income, specific information regarding dependents of a veteran will be documented and reported. A dependent is defined as a person who is the legal and financial responsibility of the veteran. Thus, a dependent could be, but is not limited to, children under the age of 18 who live with the veteran, aging parents who live with the veteran, or any stepchildren, foster children, or other dependent. If the veteran reports the dependent to the IRS (Internal Revenue Service) when filing taxes, the person should be reported under item 3.

(3) An entry will be made in all applicable spaces. If there are no dependents, enter "none."

(4) Item 1: Check the appropriate box to indicate the veteran's current marital status.

(5) Item 2A: Indicate whether veteran was married during last calendar year.

(6) Items 2B through 2E: Complete these items only if the answer to item 2A is yes.

(7) Item 3, Dependents: Provide the name, Social Security number, sex, date of birth, and relationship to the veteran.

(8) Item 4, Previous Calendar Year Income Information: Provide the previous calendar year income information for the veteran, spouse, and dependents by the type of income shown.

(9) Item 4 (10), All Other Income: Include the dollar amount of compensation if the veteran is nonservice-connected and the spouse is service-connected (see att. 4B).

(10) Item 11, Total Income: Add and record the total previous calendar year income information for the veteran, spouse, and dependents in the appropriate column. (DHCP will calculate the total when information is entered into the computer.)

l. Part VII, items 1-6, Ineligible/Missing Data: These items will be completed when information is received from the regional office or other source that the patient is ineligible. The date, source of information, city and state, the reason, and decision will be documented in the appropriate items.

m. Part VII, items 7-11, Ineligible/Missing Data: These items will be completed when the patient has been declared missing by another facility. The date, source, city and state, and reason will be documented in the appropriate items.

n. Page 4, item 1, Eligibility Status: Enter one of the following:

Pending verification
Pending reverification
Verified

o. Page 4, item 2, Status Date: Enter the current date.

p. Page 4, item 3, Status Entered By: Enter your name. (DHCP will enter your name when information is entered into the computer.)

q. Page 4, item 4, Verification Method: Enter the source of verification, e.g., DD 214, Report of Separation from Active Duty, HINQ (Hospital Inquiry), etc.

r. Page 4, item 5, Service Verification Date: Enter the date of verification.

s. Page 4, Admission Date: Complete this information only if the patient is admitted to a VA or non-VA hospital, VA or community nursing home, domiciliary or State home facility. Do not complete this item if the patient is admitted to outpatient/ambulatory care.

t. Page 4, Authority for Admission or Treatment: Enter the numerical translation for the VA regulation which provides the appropriate authority for admission or treatment.

PROCEDURES FOR QUARTERLY APPLICATION PROCESSING TIME STUDY

4B.01 PURPOSE

- a. The quarterly application processing time study is intended to provide an assessment of the efficiency of services provided at health care facilities during the evaluation process to determine a veteran's need for medical care.
- b. The assessment consists of documentation of time intervals necessary for each applicant being examined to determine the need for medical care. Upon completion of the statistical analysis, a narrative commentary will be completed.
- c. The processing time study will be completed no less than quarterly for both application processing through triage and waiting times associated with scheduled clinic appointments.

PROCESSING VA FORM 10-10M, MEDICAL CERTIFICATE

4C.01 GENERAL

VA (Department of Veterans Affairs) Form 10-10M, is intended to provide consistency in obtaining and recording certain necessary data during the course of the physical examination, and to clearly reflect disposition action taken by the VA examining/reviewing official.

4C.02 PROCESSING INSTRUCTIONS

- a. Most of the items of VA Form 10-10M are self-explanatory.
- b. Signature of nurse or other clinical staff member completing items 1 through 10.
- c. Item 14a in Section I requires that the name of the Attending Physician for this patient be documented. Item 14b in Section I, "Examiner's Signature", is to be signed by the examining/reviewing VA clinician. Whether or not care is required or rendered, the application must be signed by a physician.

INSTRUCTIONS FOR COMPLETING VA FORM 10-10F, FINANCIAL WORKSHEET

4D.01 DEFINITIONS/INSTRUCTIONS FOR USE OF VA FORM 10-10F

a. Eligibility determinations with respect to attributable income shall be made in the same manner, including the same sources of income and exclusions from income, as determinations with respect to income are made for determining eligibility for pension. The term "attributable income" means income of a veteran for the calendar year preceding application for care, determined in the same manner as the manner in which a determination is made of the total amount of income by which the income would be calculated for pension eligibility purposes. All income before deductions for the veteran, spouse and children must be reported including all severance pay or other accrued payments. Costs and payments made by the veteran for unusual medical expenses, last illness and burial expenses for a spouse or child, and educational or vocational expenses for a spouse or child, and educational or vocational rehabilitation expenses may be deducted from income and not considered in the determination of attributable income. Excluded are proceeds from fire insurance policies and current work income of dependent children pursuing a course of primary, secondary or post secondary education or vocational rehabilitation or training.

b. VA Form 10-10F, will be completed by all veteran applicants for medical care who must declare that they are unable to defray the necessary expenses of medical care. VA Form 10-10F is to be completed before the applicant has been examined except when emergent or urgent care is necessary. The VA Form 10-10F will be updated annually on the first visit after the anniversary date originally completed.

c. Instructions for completing VA Form 10-10F follow:

SECTION A - MARITAL STATUS

1. Indicate whether veteran was married during last calendar year. If answer is "no", skip to Section B.
2. Indicate whether veteran resides with his or her spouse during last calendar year. If the veteran and spouse were living apart because one is hospitalized or in a nursing home, check "yes". If the answer to this item is "yes", skip to Section B.
3. Complete this item only if veteran indicated "yes" to item 1 and "no" to item 2. If the veteran did not live with his or her spouse and the amount entered is less than \$50, consider the veteran to be without a spouse.

SECTION B - DEPENDENT CHILDREN

Indicate whether the veteran had any unmarried children or stepchildren under the age of 18 or between the ages of 18 and 23 and who were attending school. School attendance did not have to be full time but it should have been regular. The child could have been enrolled in high school, college, or vocational school. If the child was under the age of 18, the child did not have to be attending school. DO NOT INCLUDE FOSTER CHILDREN. If the veteran reports no children, skip to Section C.

1. **Child's Name:** If the veteran has qualifying children, list their names.
2. **Permanently Incapable Of Self-Support:** Respond "yes" or "no" for any of the qualifying children who were over the age of 17 who became permanently incapable of self support before reaching the age of 18.

3. **Does The Child Live With You:** Indicate whether the child lived with the veteran during the last calendar year. If the answer is "Yes", skip to (5) of this Section. If the answer is "No", go to (4) of this Section.

4. **Do You Contribute To The Child's Support:** Complete this item only if the veteran indicated "No" to item (3) of this Section. Indicate whether the veteran contributed to the child's support during last calendar year. The contributions did not have to be in regular set amounts. For example, a veteran who paid a child's school tuition or medical bills would have contributed to the child's support. However, the contribution should have been more than a nominal amount (e.g., \$25 on the child's birthday.)

5. **Does The Child Have Any Income:** Indicate whether the child had income during last calendar year. Income payable to another person as guardian or custodian of the child is considered to be the child's income. If the child had no income, skip to item (6) of this Section for this child.

6. **Is The Child's Income Available To You:** Complete this item only if (5) is checked "Yes". Indicate whether the child's income was available to the veteran. The child's income is deemed to be available if it can be used to pay expenses of the veteran's household. For example, a Social Security check payable to the veteran's estranged spouse as custodian of the child was probably not available to the veteran. On the other hand, a Social Security check on behalf of the child payable to someone living in the veteran's household was probably available.

SECTION C - PREVIOUS CALENDAR YEAR INCOME

1. **Item 1 through 10.** Enter the total income received by the veteran from each indicated source during the previous calendar year.

2. **Spouses Income.** If in Section A, the veteran checked "yes" in Item 1 and "yes" in item 2, or if the veteran checked "no" in item 2 and entered at least "\$50" in item 3, show the total income received by the veterans spouse in the "Spouse" column.

3. **Child's Income.** If, in Section B, the veteran checked "no" for either "Does The Child Live With You" and "Do You Contribute To The Child's Support" for any child, do not report that child's income. If the veteran checked "yes" for either of these questions, enter the child's first name at the top of one of the blank columns and furnish total income received by the child during last calendar year.

4. **Business or Farm Income.** Net income from operation of a farm or other business is countable.. If a veteran reports this type of income, have the veteran complete VA Form 21-4165, Pension Claim Questionnaire for Farm Income, or VA Form 21-4185, Report of Income from Property or Business. Subtract the veteran's business or farm expenses from gross income. The result should be entered on line 10. If the veteran or the veteran's spouse or child received a salary from the business, it should be reported on line 7. **NOTE:** *Depreciation is not a deductible expense for VA purposes.*

5. **Income Not Listed.** If the veteran reports a type of income not listed in lines 1 through 10, determine whether it is countable. The general rule is that all income is countable unless specifically excluded. Addendum A summarizes the major income exclusions and addendum B lists certain specific items of income which have been determined to be countable. Neither addendum is all-inclusive. If there are any questions about items not listed, contact MAS (Medical Administration Service), VA Central Office (161B2).

6. Line 11. Add all incomes entered on lines C(1) through C(10) for the veteran, spouse and children, as applicable.

SECTION D - DEDUCTIBLE EXPENSES

1. Report the total amount of un-reimbursed medical expenses paid by the veteran during the previous calendar year. The expenses can be for the veteran or for members of the veteran's family. Reportable medical expenses include amounts paid for the following:

- a. Fees of physicians, dentists, and other providers of health services.
- b. Hospital and nursing home fees.
- c. Medical insurance premiums (including the Medicare premium).
- d. Drugs, medicines, and eyeglasses.
- e. Any other expenses that are reasonably related to medical care.

The expenses must actually have been paid by the veteran. Do not list expenses which have not been paid or which have been paid by someone other than the veteran. Do not list expenses which the veteran has paid if the veteran expects to receive reimbursement from insurance or some other source.

2. Report amounts paid by the veteran during the previous calendar year for funeral or burial expenses of the veteran's spouse or child. Do not report amounts paid for funeral or burial expenses of other relatives such as parents, siblings, etc.

3. Report amounts paid by the veteran during the previous calendar year for the veteran's educational expenses. Do not report educational expenses of the veteran's children or spouse on line 3. Educational expenses include amounts paid for tuition, fees, and books if the veteran is enrolled in a program of education.

4. Indicate whether any employment income was reported for a child on line 7 of Section C. If "no", go to line 10.

5. Enter the previous year's 38 CFR (Code of Federal Regulations) 3.272(j)(1), exclusion. This amount changes each January 1st and can be obtained from MAS, VA Central Office (161B). Effective January 1, 1991, this amount was \$5,500. Effective January 1, 1992, this amount was \$5,900.

6(A). List the first name of each child for whom employment income was reported on line 7 of Section C. Do not list any child who did not have employment income.

6(B). Carry forward the child's employment income from line 7 of Section C.

6(C). Carry forward the exclusion from item 5 of this Section.

6(D). Subtract amount in 6(C) from amount indicated in 6(b). If the result is 0 or less, skip 6(E) and enter "0" in 6(F).

6(E). Enter child's educational expenses if child was enrolled in a program of education beyond the high school level during the previous calendar year. Educational expenses include amounts paid for tuition, fees, and books.

6(F). Subtract amount in 6(E) from the amount indicated in 6(D) and enter the result. If the result is less than zero, enter "0".

7. Add the entries in column 6(B).
8. Carry forward the entry from 6(F).
9. Subtract line 8 from line 7 and enter the result.
10. Add the entries from lines 1, 2, 3, and 9 of this Section.
11. Subtract line 10 Section D from line 11 of Section C. The result is the Attributable Income.

SECTION E - NET WORTH

1. Enter each family member's cash and amounts in bank accounts as of the end of the previous calendar year. This includes checking accounts, savings accounts, individual retirement accounts, certificates of deposit, etc.

2. Enter each family member's stocks, bonds, and similar assets as of the end of the previous calendar year. The reportable value of the stock or bond is the amount of money that the asset would bring if it were cashed out today.

3. Enter the value, less mortgages or other encumbrances, of any real property (land and buildings) owned by each family member as of the end of the previous calendar year. Do not report the value of the veteran's primary residence. If the veteran's primary residence was a multifamily dwelling, report the value of the building less the value of the unit occupied by the veteran. If the veteran lived on a farm, report the value of the farm less the value of the house occupied by the veteran and a reasonable surrounding area. VA forms and instructions indicated in paragraph 4.29(c) of this chapter will be followed in determining reasonable value of farms, ranches and small businesses.

4. Report the market value of any other property owned by each family member as of the end of the last calendar year. However, do not report the value of household effects or vehicles regularly used for family transportation.

5. Enter debts, as of the end of the last calendar year, that will reduce the value of the property listed on line 4 of the Section. **DO NOT INCLUDE ANY CREDIT CARD DEBTS.**

6. Add lines 1, 2, 3 and 4 and subtract line 5 of this Section. The result is net worth. Line 5 **CANNOT EXCEED** the figure entered on line 4 of this Section.

ADDENDUM A **INCOME EXCLUSIONS**

The major income exclusions are as follows: (Do not list these types of income on the worksheet.)

a. **Welfare and SSI (Supplemental Security Income).** Generally, any type of benefit which is payable based on the veteran's financial need is not counted.

b. **Maintenance.** The value of maintenance is not counted. In other words, if someone furnishes the veteran free room and board or pays the veteran's bills, the value of room and board or the amount of the extinguished debt is not countable. However, if someone gives the veteran a cash gift and the veteran uses this cash to pay bills, the gift is countable.

c. **Proceeds of Casualty Insurance.** If veteran loses property due to fire, flood, theft, etc. and the veteran collects on an insurance policy, the amount received is not countable as long as it does not exceed the value of the lost property.

d. **Profit from Sale of Property.** If the veteran occasionally sells property and receives money, the veteran does not receive countable income - even if the amount received exceeds the value of the property. However, profit from sale of property is countable if the veteran sells the property as part of a regular business.

e. **Income from Domestic Volunteer Service Act Programs.** Income received from participation in an action agency program is not countable.

f. **Agent Orange Settlement Payments.** Payments received in settlement of the case - Agent Orange Product Liability Litigation in the U.S. District Court for the Eastern District of New York are not countable.

g. **Mineral Royalties.** Royalties received for extracting minerals are not countable. However, bonus payments and delay rentals are countable.

h. **Income Tax Refunds.** Income tax refunds (including the Federal Earned Income Credit) are not countable.

i. **Withheld Social Security.** Social security or similar benefits withheld to recoup a prior overpayment are not countable. Count the check amount plus any Medicare deduction. However, if the withholding is due to legal action by a third party (such as a garnishment order) count the gross benefit.

j. **Distributions from VA Special Therapeutic and Rehabilitation Activities Fund.** Payments made as a result of a veteran's participation in a therapeutic or rehabilitation activity under 38 U.S.C. 618 are not countable. This exclusion applies only to therapeutic and rehabilitation activities under the auspices of a VA medical center.

k. **Home Energy Assistance Act.** Grants for heating and cooling homes under the Home Energy Assistance Act (Pub. L. 96-223) are not countable.

l. **Interest on Individual Retirement Accounts.** Such interest is generally not countable if it cannot be withdrawn without incurring a substantial penalty.

m. **Chore Services Payments.** Amounts paid by a governmental entity to an individual to care for a disabled veteran in the veteran's home are not countable provided eligibility for the payments is based on the veteran's financial need. It does not matter whether the payments are made to the veteran or directly to the person performing the services.

n. **Loans.** Amounts loaned to a veteran are not countable income as long as the veteran incurs a legally binding obligation to repay the loan. Loans must be distinguished from gifts which are countable.

- o. **Crime Victims Compensation Act payments.** Amounts paid by governmental entities to compensate crime victims are not countable provided eligibility for the payments is based on financial need.
- p. **Provisional Income.** If a veteran is awarded some benefit (e.g., black lung benefits) but it is later determined that the veteran is not eligible for the amount awarded and the veteran makes a complete repayment, the income is not countable. If the veteran repays less than the total amount awarded, count the difference between the amount awarded and the amount repaid.
- q. **Scholarships and Grants for School Attendance.** Payments earmarked for specific educational purposes are not countable income.
- r. **Survivor Benefit Annuity under Section 653, Public Law 100-456.** Amounts paid by the Department of Defense under Public Law 100-456 to the surviving spouse of a veteran who died prior to November 1, 1953, are not countable.
- s. **California State Renter's Credit.** This is considered to be a welfare payment and is not countable.
- t. **Relocation Expenses.** Relocation expenses paid under the Uniform Relocation Assistance Act (42 U.S.C. (United States Code) 4601) to assist persons displaced by Federal and Federally assisted projects are not countable.
- u. **Disaster Relief Payments.** Voluntary payments in the nature of relief after widespread national disaster such as floods and hurricanes, are not countable.
- v. **Farmers' Home Administration Construction Grants.** Grants made by the Farmers Home Administration to needy families in rural areas for repairs or improvements to structures are not countable.
- w. **Insurance Dividends.** These are considered to be a return of excess premium payments and are not countable. However, if insurance dividends are left on deposit, any interest earned is countable.
- x. **Timber Sales.** Do not count income from sale of timber unless it is received in the course of business.
- y. **Payments to Foster Parents.** Do not count as income, payments made by a State or subdivision of a State to foster parents for care of foster children.

ADDENDUM B MISCELLANEOUS COUNTABLE INCOME

The major classes of countable income are listed in Section C lines 1 through 9. Major exclusions are listed in Addendum A. The following is a summary of income sources which have been determined to be countable. These items should be placed in Section C line 10, All Other Income.

- a. **Benefits Subject to Garnishment.** If a veteran's benefits (such as Social Security) are subject to involuntary withholding due to legal action initiated by a third party, count the entire amount even though the veteran does not receive it all. **NOTE:** *If benefits are withheld to recoup an overpayment of the benefit, only the actual amount received is countable.*

- b. **Social Security Lump Sum Death Benefit.** This is countable like other Social Security benefits.
- c. **IRA (Individual Retirement Account) Distributions.** When an IRA or similar instrument starts paying benefits, the entire amount is countable, even though it represents a partial return of principal.
- d. **Withdrawal of Contributions to Retirement Fund.** If a veteran receives a distribution of retirement benefit, the entire amount received is countable.
- e. **Department of Labor Employment Programs.** Income received by participants in programs operated by the Department of Labor, such as the Green Thumb program and the Older Americans Community Service Employment program is countable.
- f. **VA Benefits.** VA education or compensation (including DIC (Dependency and Indemnity Compensation)) benefits are countable. VA pension benefits are not countable.
- g. **Value of Room and Board.** The fair value of room and board furnished a veteran is countable income if room and board is furnished in return for services of the veteran. Room and board is not countable if it is not in connection with the veteran's employment.
- h. **Gifts and Inheritances of Property or Cash.** These are countable as received. The value of a gift or inheritance of property is the fair market value of the property at the time it is received. The value of a financial instrument such as a stock certificate or bond is the amount it would bring if it were cashed out upon receipt, even though this might be less than its face value.

4D.02 PROCESSING OF VA FORM 10-10F, FINANCIAL WORKSHEET

- a. When line 7 of Section E is greater than the income threshold amounts for Discretionary veterans, then the veteran must agree to pay the applicable copayment to VA in order to establish eligibility for medical care as a veteran. Discretionary veterans who refuse to agree to pay applicable co-payments to the VA can receive care as humanitarian emergencies only and will be billed for such care as an ineligible veteran.
- b. When line 7 of Section E is greater than \$50,000, the veteran will be placed in the Discretionary category. VA Form 10-10, 10-10F, along with all appropriate backup documents such as VA Forms 21-4185, 21-4165, and 21-8049, Request for Details of Expenses, will be forwarded to the local VBA (Veterans Benefits Administration) Regional Office with a VA Form 10-7131, per paragraph 4.29(d) of this chapter, for further development.
- c. Chief of MAS, will establish a control mechanism to ensure that all cases forwarded to the regional office are returned in a timely manner. The List Required/Pending Means Test in the DHCP will list all cases forwarded to the regional office and the date of the original VA Form 10-10F.
- d. If VBA determines that the veteran's net worth places the veteran in the Mandatory Category, then the veteran's means test category will be changed in the computer.

e. Income and assets in other than U.S. dollars will be converted to U.S. dollars using the appropriate exchange rate prior to the application of the means test. The Adjudication Officer at the Washington, DC, Regional Office will supply the correct conversion factor.

NOTE: *The Department of Veterans Affairs is authorized to bill insurance carriers for the cost of medical care furnished to all veterans for NSC conditions covered by health insurance policies. Veterans are not responsible and will not be charged for any copayment or coinsurance required by their health insurance policies.*

DETERMINATION OF COPAYMENT FOR VA CARE - DISCRETIONARY VETERANS

4E.01 GENERAL

a. NSC (nonservice-connected) veterans with annual incomes exceeding mandatory income thresholds may be furnished needed medical care if the veteran agrees to make certain co-payments to VA in connection with the care. VA Form 10-0106, Patient's Copayment Record, may be utilized to maintain a written record of the applicable copayment for the medical care rendered to individual veterans. Locally devised forms or computer output may be used provided they have the same information as a minimum.

b. To compute discretionary co-payments on VA Form 10-0106, it is necessary to simultaneously track three different time periods that are unique for each veteran. These three time periods are:

- (1) Three hundred sixty-five calendar days from the veteran's date of application.
- (2) Four 90-day billing cycles.
- (3) Ninety days of actual hospital or nursing home care.

c. Pass and leave days will not be counted toward the 90 days of actual hospital or nursing home care.

d. Bills for medical care rendered to individual discretionary NSC veterans should be prepared at least monthly by MAS (Medical Administration Service) and forwarded to Fiscal Service for collection activity on an ongoing basis.

e. For any one episode of hospital or nursing home care the day of admission is counted, but not the day of disposition. Hospitalization for less than 24 hours following admission, when hospital care is terminated by transfer, discharge or death, will be counted as 1 day of care. The day of departure for any absence of more than 24 hours is not counted in computing hospital or nursing home days. Count the day of the patient's return from absence except when disposition is effected on that day.

f. Hospital Care Co-payments. When a veteran is admitted to the hospital for only 1 day the law requires the individual be billed for the lesser of the cost of furnishing care (1-day inpatient stay) or the amount of the inpatient Medicare deductible in effect at the beginning of a 365-day period (anniversary date of VA Form 10-10 completion). VA billing rates and Medicare deductibles are changed annually, but may have different effective dates.

g. Co-payments must be paid by veterans for medical care provided through auspices of VA.

4E.02 NURSING HOME CARE CO-PAYMENTS

For each 90-day period, or part thereof, a discretionary veteran is in a VA or contract nursing home during a 365-day period, they are obligated to pay the current Medicare billing rate. The Medicare billing rate is not reduced by half as it is for hospital care for subsequent 90 day episodes.

4E.03 HOSPITAL CARE AND NURSING HOME CARE CO-PAYMENTS

a. When a veteran pays an amount equal to one-half of the Medicare billing rate in connection with receiving hospital care, and before using 90 days of such care within the 365-day period received nursing home care, the veteran will be required to pay a second amount equal to one-half of the inpatient Medicare deductible in connection with the number of days of nursing home care that, when added to the days of hospital care, do not exceed 90 days within the 365-day period.

b. Outpatient Care Co-payments. Outpatient visits are billed at 20 percent of VA outpatient billing rate.

c. Co-payments for collateral visits are billed as an outpatient visit to the individual veteran.

4E.04 HOSPITAL CARE, NURSING HOME CARE AND OUTPATIENT CARE

When a veteran receives a combination of hospital, nursing home and/or outpatient care in any 90-day period in a 365-day period, the veteran is not required to pay an amount greater than the Medicare billing rate for all care received during that 90-day period.

4E.05 FEE BASIS CARE CO-PAYMENTS

For each 90-day period a discretionary veteran must pay or agree to pay 20 percent of VA outpatient billing rate or the actual cost of the care if it is less than the copayment.

4E.06 SUMMARY OF COPAYMENT DETERMINATIONS

DISCRETIONARY PAYMENTS

a. Within each 90-day billing period the veteran pays no more than the Medicare deductible that was in effect on the first day of the 365-day period.

b. For initial hospital admissions during the 365-day period, the veteran pays the lesser of the actual cost of care (1-day stays) or the Medicare deductible.

c. For each additional 90 days of hospital care, the veteran pays one-half the Medicare deductible.

d. For each 90 days of nursing home care, the veteran pays the Medicare deductible.

NOTE: *In addition to the above co-payment, the veteran will be charged a fee of \$10 per day for inpatient hospital care and \$5 per day for nursing home care.*

e. At the end of four consecutive 90-day billing periods, the remaining 5 days of the calendar year are at no cost to the veteran.

f. On day 366, the clock is reset to day 1. It is not necessary to do a new VA Form 10-10F as long as the veteran remains active in either an inpatient or outpatient treatment status.

January 6, 1993

1. Transmitted is a revision to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 4, "Hospital and Domiciliary Care." Brackets have not been used to indicate the changes.

2. Principal changes are:

a. Editorial changes:

(1) To incorporate "medical or psychiatric" when referring to emergency care in order to strengthen procedures relative to patients presented for emergency care.

(2) To replace the "Category A" veteran category with "mandatory veteran" category wherever mentioned. To replace the "Category B and C" veteran category with "discretionary veteran" category wherever mentioned.

b. **Paragraph 4.01b:** A new paragraph describing the responsibilities of the AOD (Administrative Officer of the Day) and requests each medical facility director clearly define the duties and responsibilities of the AOD in local policy and procedure directives.

c. **Paragraph 4.03:** Subparagraphs a. through j. removed. Reader is directed to M-1, part I, chapter 24, section III for information.

d. **Paragraph 4.15:** New section on decision and notices denying health care related benefits.

e. **Paragraph 4.18:** Indicates renal dialysis workload will be recorded as an outpatient visit rather than a 1-day admission.

f. **Paragraph 4.22:** Added new group of veterans under "U.S. civilian employees of airlines contracted during W.W.II.

g. **Paragraph 4.26:** Added new priority groups to list of eligibles.

h. **Paragraph 4.28:** Incorporates method for computing "Farm and Small Business Income" on worksheet.

i. **Paragraph 4.37:** Clarifies definition of General Discharge in regard to accessing VA health care.

j. **Appendix 4D:** Revised VA Form 10-10F, Financial Worksheet, reporting instructions.

k. **Appendix 4E:** Incorporates the \$10 and \$5 per day co-payment provisions for VA hospital and nursing home inpatient care.

3. Filing Instructions

Remove pages

4-i through 4-iv
4-1 through 4-39
4A-1 through 4E-3

Insert pages

4-i through 4-iv
4-1 through 4-40
4A-1 through 4E-2

4. **RESCISSIONS:** M-1, part I, chapter 4, dated March 16, 1989.

JAMES W. HOLSINGER, JR., M.D.
Under Secretary for Health

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FD

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