VFW GUIDE FOR POST SERVICE OFFICERS

Part 3

VETERANS OF FOREIGN WARS.

PART 3: HEALTH CARE

VETERANS OF FOREIGN WARS®

PART 3

HEALTH CARE

Contents:

MEDICAL TREATMENT

ELIGIBILITY

Sec. 1. Basic Eligibility for VA Health Care: The primary factor in determining a veteran's eligibility to receive VA health care benefits is "veteran status". "Veteran status" is established by active duty service in the military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Members of the Reserves and National Guard who are disabled during inactive duty training may be considered veterans under the law (see 38 CFR 3.6).

In addition, the following veterans must have completed 24 continuous months of active military service:

- Former enlisted persons whose first term of active duty began after September 7, 1980, or
- Former enlisted persons who originally signed up under a delayed entry program on or before September 7, 1980, and who subsequently entered active duty after that date, or
- Former commissioned officers and warrant officers whose first term of active duty began after October 16, 1981, or
- Any other person (officers as well as enlisted) who entered on active duty after October 16, 1981, and who had not previously completed at least 24 months of continuous active duty service or had been discharged or released from active duty under section 1171 of Title 10 United States Code (early out).

The 24 continuous months of active duty service requirement does not apply to:

- Reservists who were called to Active Duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge, or
- National Guard members who were called to Active Duty by federal executive order, and who completed the term for which they were called, and who were granted an other than dishonorable discharge, or
- Veterans requesting a benefit for or in connection with a service-connected (SC) condition or disability; or
- Veterans who were discharged or released from active duty under the early out program or for hardship, or
- Veterans who were discharged or released from active duty for a disability incurred or aggravated in line of duty, or
- Veterans who have been determined by VA to have compensable service-connected conditions, or
- Veterans receiving treatment and/or counseling for sexual trauma that occurred while on active military service, for treatment of conditions related to ionizing radiation or for head or neck cancer related to nose or throat radium treatment while in the military, or
- Veterans who complete their enlistment contract, which is less than 24 months.

Sec. 2. Eligibility for Medical Care for National Guard and Reserves: Reservists who were called to active duty and National Guard members who were called to active duty by federal executive order, who completed the term for which they were called, and who received an other than dishonorable discharge have established veteran status.

Sec. 3. Hospital Care and Medical Services (Priority Groups): To receive health care, veterans generally must be enrolled with VA. They may apply for enrollment at any time. Veterans do not have to be enrolled if they have a service-connected disability of 50 percent or more, want care for a disability that the military determined was incurred or aggravated in the line of duty, but which VA has not yet rated during the 12-month period following discharge, or want care for a service-connected disability only. To permit better planning of health resources, however, these three categories of veterans also are urged to enroll. Veterans will be enrolled to the extent Congressional appropriations allow. If appropriations are limited, enrollment will occur based on the following Priority Groups:

Enrollment Priority 1: Veterans with service-connected disabilities who are rated 50 percent or more disabled or are determined by VA to be unemployable due to a service-connected disability, or received the Medal of Honor (MOH).

Enrollment Priority 2: Veterans with service-connected disabilities who are rated 30 or 40 percent disabled.

Enrollment Priority 3: Veterans, who are former POWs, awarded a Purple Heart, veterans with disabilities rated 10 and 20 percent, veterans discharged from the military for disabilities incurred in the line of duty and veterans awarded special eligibility for disabilities incurred in treatment or vocational rehabilitation.

Enrollment Priority 4: Veterans who are receiving aid and attendance or housebound benefits and veterans who have been determined by VA to be catastrophically disabled.

Enrollment Priority 5: Nonservice-connected and noncompensable 0% service-connected veterans who are determined to be unable to defray the expenses of needed care, in receipt of VA pension, or eligible for Medicaid.

Enrollment Priority 6: compensable 0% service-connected veterans; veterans exposed to ionizing radiation during the occupation of Hiroshima or Nagasaki, Japan and during atmospheric testing; Project 112/SHAD participants; veterans exposed to herbicides while serving in Vietnam, Blue Water Navy Veterans, served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987; veterans who served in the Southwest theater of operations from August 2, 1990, through November 11, 1998; veterans who served in a theater of combat operations after November 11, 1998 as follows:

- Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge.
- Combat Veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their 5 year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act.

Enrollment Priority 7: Veterans who agree to pay specified co-payments with income below the geographic means test income threshold.

Enrollment Priority 8: Veterans with income and/or net worth above the VA National Income Thresholds and the VA National Geographic Income Thresholds who agree to pay specified co-payments may be enrolled in one of the four category 8 subpriority groups.

Subpriority group 8a, noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date and/or placed in this subpriority group due to changed eligibility status.

Subpriority group 8b, noncompensable 0% service-connected veterans enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Threshold or Geographic Income Threshold by 10% or less.

Subpriority group 8c, nonservice connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority group due to changed eligibility status.

Subpriority 8d, nonservice-connected veterans enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less.

Subpriority group 8e, all remaining noncompensable 0% service connected veterans not meeting the above criteria.

Subpriority group 8f, (none)

Subpriority group 8g, all remaining nonservice-connected veterans not meeting the above criteria.

NOTE: On January 17, 2003, VA suspended enrolling new applicants who are only eligible for assignment in Priority Group 8. Veterans who applied for enrollment prior to January 17, 2003 and who were in an enrolled status on that date were not impacted by the enrollment decision.

These groups are enrollment priorities only. The services and treatment available to enrolled veterans generally are not based on enrollment priority groups. All enrolled veterans have access to a standard health benefits package (38 CFR 17.38). Additional information on enrollment, including enrollment forms and online applications, also can be found on at www.va.gov/healtheligibility.

Filipino Commonwealth Army Veterans: Any Filipino Commonwealth Army veteran, including one who was recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, or any new Philippine Scout is eligible for hospital care, nursing home care, and outpatient medical services within the United States in the same manner and subject to the same terms and conditions as apply to U.S. veterans, if such veteran or scout resides in the United States and is a citizen or lawfully admitted to the United States for permanent residence. For purposes of VA health care benefits, the standards described in 38 CFR 3.42(c) will be accepted as proof of U.S. Citizenship or lawful permanent residence. U.S. Commonwealth Army Veterans, including those who were recognized by authority of the U.S. Army as belonging to organized Filipino guerilla forces, and new Philippine Scouts are not eligible for VA health care benefits if they do not meet the residency and citizenship requirements. Old Filipino Scouts are also eligible for VA health care benefits; however, they do not have to meet the citizenship and residency requirements as they are considered veterans under the law.

Recovery of reasonable cost: VA is authorized to recover from health insurers the reasonable cost of health care furnished in VA facilities to insured non-service-connected (NSC) veterans or service-connected veterans for care received for their non-service-connected conditions.

Application for health care benefits: Veterans may apply for enrollment in the VA health care system by completing a VA form 10-10EZ, *Application for Health Benefits*, in person at a VA Medical Center, or by submitting a completed VA Form 10-10EZ to their local VA health care facility by mail or online at https://www.1010ez.med.va.gov/. The office receiving the application will process the application, including making a preliminary determination of the veteran's eligibility for enrollment. Veterans applying by mail or online will be scheduled for an appointment if requested on their application. Applicants applying in person presenting a *bona fide* medical emergency will be provided medical care immediately prior to determination of basic eligibility.

Beneficiary Travel: Beneficiary travel payments or reimbursement may be made to certain veterans in connection with receiving VA health care services. Those eligible:

- A veteran with a VA service-connected rating of 30 percent or more, or
- A veteran rated below 30 percent and traveling in connection with treatment of a service-connected disability, or
- A veteran who is in receipt of VA pension, or
- A veteran whose income is less than or equal to the maximum annual VA pension rate, or
- A veteran traveling in connection with a compensation and pension examination.

Special Mode Transportation: Veterans who meet eligibility criteria and whose medical condition as determined by a VA provider requires use of a special mode of transportation (ambulance, wheelchair van etc.) may receive such transportation at VA expense. Special mode travel must be pre-authorized by VA unless it is a medical emergency.

Mileage Reimbursement: The current mileage rate is 41.5 cents per mile. Mileage reimbursement is subject to a deductible, of $3.00 one-way ($6.00 round-trip) with a calendar month cap of $18.00 or 6 one-way (3 round) trips, whichever occurs first. Once the cap is reached travel payments made for the balance of that particular month are free of deductible charges. A waiver of the deductible will be provided if:

- the veteran is in receipt of a VA pension, or
- a NSC veteran and the previous year's income does not exceed, or the projected current calendar year's income, in the year of application will not exceed the applicable VA pension rate, or
- a SC veteran and the previous year's income does not exceed, or projected current calendar year's income, in the year of application will not exceed the applicable national means test income threshold, or,
- traveling for a scheduled compensation and pension exam.

TRICARE beneficiaries may be eligible for both veterans' and TRICARE benefits. Veterans are considered "dual-eligible" when they are eligible for both veterans' medical benefits and TRICARE benefits. Veterans seeking care for a service-connected condition in VA medical facilities must receive that care under their veterans' benefits. VA may not bill TRICARE for treatment of service-connected conditions.

BENEFITS PACKAGE

Sec. 4. Medical Benefits: Care referred to in the Medical Benefits Package will be provided to individuals only if is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with general accepted standards of medical practice. Services covered under the Medical Benefits Package are as follows:

A. Outpatient medical, surgical, and mental health care, including care for substance abuse.
B. Inpatient hospital, medical, surgical, and mental health care, including care for substance abuse.
C. Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.
D. Emergency care in VA facilities.

E. Emergency care in non-VA facilities in certain conditions: This benefit is a safety net for veterans requiring emergency care for a service-connected disability or enrolled veterans who have no other means of paying a private facility emergency bill. Under this last scenario, if another health insurance provider pays all or part of a bill, VA cannot provide any reimbursement. To qualify for payment or reimbursement for non-VA emergency care service for a service-connected disability, you must meet all of the following criteria: It must be for a medical emergency, Department of Veterans Affairs or other federal facilities are not feasibly available at time of emergency event, and the emergency was for a service-connected disability. To qualify for payment or reimbursement for non-VA emergency care services for a nonservice-connected condition, veterans must meet all of the following criteria:
    1. Be enrolled in the VA Health Care System.
    2. Have been provided care by a VA clinician or provider within the last 24 months.
    3. Was provided care in a hospital emergency department or similar facility providing emergency care.
    4. Have no other form of health insurance. Have no coverage under Medicare, Medicaid, or a state program. Have no coverage under any other VA programs.
    5. Department of Veterans Affairs or other Federal facilities are not feasibly available at time of emergency event.
    6. A reasonable layperson would judge that any delay in medical attention would endanger your health or life.
    7. You are financially liable to the provider of the emergency treatment for that treatment.
    8. You have no other contractual or legal recourse against a third party that will pay all or part of the bill.
F. Bereavement counseling.
G. Comprehensive rehabilitative services other than vocational services.
H. Consultation, professional counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran.
I. Durable medical equipment and prosthetic and orthotic devices.

Note: Eyeglasses and hearing aids are limited to veterans with a compensable service-connected disability, former prisoners of war, Purple Heart recipients, in receipt of A&A or HB benefits or who have significant functional or cognitive impairments. Hearing aids may also be provided to non-compensable 0% veterans as needed for the SC hearing disability. The new process, the Audiology and Optometry Direct Scheduling Initiative, which began as a successful pilot at three sites in 2015, is being expanded to all VA Medical Centers. Veterans who need eye and ear care will now be able to directly schedule their own appointments.

J. Home health services.
K. Reconstructive (plastic) surgery required as a result of a disease or trauma but not including cosmetic surgery that is not medically necessary.
L. Respite, hospice, and palliative care.
M. Payment of travel and travel expenses for eligible veterans (see Beneficiary Travel requirements above).
N. Pregnancy and delivery service, to the extent authorized by law.
O. Completion of forms: This coverage includes completion of forms such as Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, and non-VA disability program forms by health care professionals based on an examination or knowledge of the veteran's condition. This does not include the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

Preventive care includes: Periodic medical exams; health education, including nutrition education, maintenance of drug-use profiles, drug monitoring, and drug use education; and mental health and substance abuse preventive services.

The "Medical Benefits Package" does not include the following:

A. Abortions and abortion counseling.
B. Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.
C. Gender alteration surgery.

D. Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services; and
E. Membership in spas and health clubs.

Special Services:

A. A veteran may receive certain types of VA hospital and outpatient services and care not included in Medical Benefits Package as outlined in 38 C.F.R. 17.37 to include: compensation and pension examinations, dental care, readjustment counseling, care as part of a VA-approved research project, sexual trauma counseling and treatment, special registry examinations.
B. A veteran may receive an examination to determine whether the veteran is catastrophically disabled and therefore eligible for inclusion in priority group 4.

Enrollment not required:

A. A veteran rated for service-connected disabilities at 50 percent or greater will receive VA Hospital and outpatient care.
B A veteran who has a service-connected disability will receive VA hospital and outpatient care for that service-connected disability.
C. A veteran who was discharged or released from active military service for a disability incurred in or aggravated in the line of duty will receive VA hospital and outpatient care for that disability for the 12-month period following discharge or release.
D. When there is compelling medical need to complete a course of VA treatment started when the veteran was enrolled in the VA health care system, a veteran will receive that treatment.
E. A veteran participating in VA's vocational rehabilitation will receive VA hospital and outpatient care.
F. A veteran may receive VA hospital and outpatient care based on factors other than veterans status, e.g., a veteran who is a private hospital patient and is referred to VA for a diagnostic test by that hospital under a sharing contract; a veteran who is a VA employee and is examined to determine physical or mental fitness to perform official duties; a Department of Defense retiree under a sharing agreement.
G. A veteran may receive VA hospital and outpatient care outside the United States, (Foreign Medical Program (FMP), without regard to the veteran's citizenship, if necessary for treatment of a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability or if the care is furnished to a veteran participating in a VA rehabilitation program.
H. A veteran otherwise authorized by statute or regulation (for example, veterans not enrolled who need a C&P examination pursuant to a claim for service connection).

Note: Authority 38 CFR 17.37

Sec. 5. Inpatient and Outpatient Copays:

Copays for inpatient hospital care: With certain exceptions a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract), must agree to pay VA (and is obligated to pay VA) the applicable copay. Priority Group 8 veterans pay, during any 365-day period, a copay equaling the sum of $10 for every day the veteran receives inpatient hospital care, and the lesser of the sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or; VA's cost of providing the care. Priority Groups 7 veterans pay 20% of this rate.

NOTE: The requirement that a veteran agree to pay the copay would be met by submitting to VA a signed VA Form 10-10EZ, "Application for Health Benefits" or VA Form 10-10EZR, Health Benefit Renewal. The VA Form 10-10EZ is the application form for enrollment in the VA healthcare system; the 10-10EZR is the document used for providing updated personal and means test information annually.

Copays for outpatient medical care: The copay for outpatient medical care is $15 for a primary care outpatient visit and $50 for a specialty care outpatient visit. If a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copay amount is the copay for one primary care outpatient visit. If a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copay amount is the copay for one specialty care outpatient visit.

A primary care visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained

partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic bio-psychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. In contrast, specialty care is generally provided through referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

Care not subject to the copay for outpatient care:

A. A veteran with a compensable service-connected disability.
B. A veteran who is a former prisoner of war.
C. A veteran awarded a Purple Heart.
D. A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty.
E. A veteran who receives disability benefits under 38 U.S.C. 1151.
F. A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151.
G. A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay.
H. A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106-117 the *Veterans Millennium Health Care and Benefits Act*.
I. A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722.
J. A veteran who is determined by VA to be Catastrophically Disabled.

The following are not subject to the copay requirements under this section:

A. Care provided to a veteran for a non-compensable zero percent service-connected disability.
B. Care authorized under 38 U.S.C. 1710(e) for; veterans requiring care possibly related to their exposure to herbicides while serving in Vietnam, veterans requiring care possibly related to their service in the Southwest theater of operations from August 2, 1990 through November 11, 1998, combat veterans for five years after discharge for conditions possibly related to their service in a combat area or until January 27, 2011 for veterans discharged before January 28, 2003 who enrolled after January 27, 2008; veterans associated with ionizing radiation exposure; veterans requiring care possibly related to participation in Project 112/SHAD.
C. Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service.
D. Counseling and care for sexual trauma as authorized under 38 U.S.C. 1720D.
E. Compensation and pension examinations requested by the Veterans Benefits Administration.
F. Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303.
G. Outpatient dental care provided under 38 U.S.C. 1712.
H. Readjustment counseling and related mental health services authorized under 38 U.S.C. 1712A.
I. Emergency treatment paid for under 38 U.S.C. 1725 or 1728.
J. Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.
K. Publicly announced VA public health initiatives (e.g., health fairs) or an outpatient visit solely consisting of preventive screening and immunizations (e.g. influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening).
L. Laboratory services, flat film radiology services, and electrocardiograms.
M. Smoking cessation counseling (Individual and group).
N. Weight management counseling (Individual and group).
O. Hospice care.

Urgent Care Program. Based on Veteran's assigned Priority Group and required copayment.

- Priority Group 1-5 – There is no copayment for the first three visits during a calendar year. For the fourth visit and all subsequent visits in a calendar year, the copayment is $30.

- Priority Group 6 – There is no copayment for the first three visits during the calendar year if the visit is related to special authority* or exposure. For the fourth visit and all subsequent visits in a calendar year, the copayment is $30 pervisit, regardless of which visit it is.
- Priority Group 7-8 - $30 copay per visit.
  * Special authorities include those related to combat service and exposures (e.g. agent orange, active duty at Campy Lejeune, ionizing radiation, Project Shipboard Hazard and Defense (SHAD/Project 112), Southwest Asia Conditions) as well as Military Sexual Trauma, and presumptions applicable to certain Veterans with psychosis and other mental illnesses.

Urgent care locator has been integrated into VA's facility locator tool: https://www.va.gov/find-locations/ .

Additional care not subject to outpatient copays. Outpatient care is not subject to the outpatient copay requirements when provided to a veteran during a day for which the veteran is required to make a copay for extended care services that were provided either directly by VA or obtained for VA by contract

Sec. 6. Medication Copays: Effective February 27, 2017, Veterans in Priority Groups 2-8, are required to pay for each 30-day or less supply of medication for treatment of nonservice-connected condition (unless otherwise exempt).

• 30-day or less supply for Tier 1 (Preferred Generics) Medications for certain Veterans:
$5

• 30-day or less supply for Tier 2 (Non-Preferred Generics & some OTCs) Medications for certain Veterans:
$8

• 30-day or less supply for Tier 3 (Brand Name) Medications for certain Veterans:
$11

The total amount of copays in a calendar year for a veteran enrolled in Priority Groups 2 through 8 are limited to $700 annual cap.

Medication not subject to the copay requirements: The following are exempt from copays:

A. Medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability;
B. Medication for a veteran's service-connected disability;
C. Medication for former prisoners of war;
D. Medication for a veteran whose annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of VA pension which would be payable to such veteran if such veteran were eligible for pension under 38 U.S.C. 1521;
E. Medication authorized under 38 U.S.C. 1710(e) for combat veterans for five years after discharge for conditions possibly related to their service in a combat area or until January 27, 2011 for veterans discharged before January 28, 2003 who enroll after January 27, 2008; veterans associated with ionizing radiation exposure; veterans requiring care possibly related to participation in Project 112/SHAD;
F. Medication for treatment of sexual trauma as authorized under 38 U.S.C. 1720D;
G. Medication for treatment of cancer of the head or neck authorized under 38 U.S.C. 1720E; and
H. Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303.
I. Medication for veterans found by VA to be Catastrophically Disabled.

Prescriptions in Alaska, Territories and Possessions: In Alaska, territories and possessions, where there is no Department of Veterans Affairs pharmacies, the expense of any prescriptions filled by a private pharmacist which otherwise could have been filled by a Department of Veterans Affairs Pharmacy under current regulations may be reimbursed.

Sec. 7. Cost Recovery: VA is authorized to recover from health insurers the reasonable cost of health care furnished in VA facilities to insured non-service-connected veterans or service-connected veterans for care received for their non-service-connected conditions.

Sec. 8. Nursing Home Care: The term "nursing home care" may include intermediate care and means the accommodation of functionally impaired or other persons who are not acutely ill and not in need of hospital care, but

who require skilled nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of persons duly licensed to provide such care. The term includes care where the nursing service is under the supervision of a registered professional nurse.

The Veterans Health Administration shall provide home care under the following circumstances:

A. Either directly or through contracts, when clinically indicated to a veteran who requires the long-term care for a service-connected condition, or is rated 70% or greater service-connected or is permanently and totally disabled for a service-connected condition or is 60% service-connected and receiving individual unemployability.
B. Based on available resources, either direct or through contracts, when clinically indicated to all other eligible veterans who need nursing home care.

Veterans should be placed in Home and Community-Based Care (HCBC) when clinically appropriate and veterans receiving Community Living Center (CLC) or Community Nursing Home (CNH) care will be transferred to appropriate assisted living or home and community-based care settings when nursing home care, at any level, is no longer clinically indicated.

As a condition of receiving extended care services, any non-exempt veteran must agree to pay VA a co-payment. The following veterans are exempt from co-payment requirements for extended care services, veterans receiving extended care services on or before November 30, 1999, and who have been continuously receiving these services since that date, veterans with a compensable service-connected disability and veterans whose annual income (determined under Title 38 United States Code (U.S.C.) 1503) is less than the single veteran nonservice-connected disability pension income amount in effect under 38 U.S.C. 1521(b).

Nursing Home Care-Public or Private: Nursing home care in a contract public or private nursing home facility may be authorized for any veteran who has been furnished care in a facility under VA auspices and requires a protracted period of nursing home care. A veteran who is furnished care by the VA in a hospital or domiciliary facility in Alaska or Hawaii may be furnished nursing home care at VA expense if such hospital and domiciliary facility is not under the jurisdiction of the VA. A veteran may only be provided public or private nursing home care if the cost of such nursing home care does not exceed 45% of the cost of care furnished by VA in a general hospital under the jurisdiction of the VA. Certain areas of the country have been approved for a higher maximum per diem rate to include Alaska and Hawaii. Placement is normally for a period of six months but may be extended and is without limitation when hospitalization was primarily for a service-connected disability. Direct admission of service-connected veterans needing nursing home care for a service-connected condition is authorized. Nursing home facilities to which veterans are transferred under this authority must meet standards prescribed by VA.

Sec. 9. Eligibility for Dental Treatment: VA may furnish outpatient dental services and treatment, and related dental appliances to:

A. Veterans having service-connected dental conditions that are rated at 10% or higher may receive any needed dental treatment.
B. Any former Prisoner of War (POW), as determined by the military service department, may be authorized any needed dental treatment.
C. Veterans whose service-connected disabilities are rated at 100% or who have been given the 100% rating for reason of individual unemployability may be authorized any needed dental treatment.
D. Veterans who are participating in a rehabilitation program under 38 U.S.C. Chapter 31 may be authorized dental services that are professionally determined necessary to assist them in the completion of their program.
E. Veterans who served on active duty for 90 days or longer may receive one episode of dental treatment for service-connected, non-compensable dental conditions if: they have application to the VA within 180 days after their discharge or release from active duty; their certificate of discharge or release indicates that their dental care was not completed within a 90-day period prior to their discharge or release from active duty.
F. Veterans may receive treatment for service-connected, non-compensable dental conditions resulting from combat wounds or service trauma.
G. Veterans having a dental condition determined to be aggravating a service-connected medical condition may be authorized dental treatment for only those dental conditions that, in sound professional judgment, are having a direct detrimental effect on the associated medical condition.
H. Veterans receiving outpatient care or scheduled for inpatient care may receive dental care if the dental condition is clinically determined to be complicating a medical condition currently under treatment.

I. Veterans enrolled in a VA Homeless Program who, for a period of 60 consecutive days, are receiving care (directly or under contract) in a VA domiciliary; a therapeutic residence operated in connection with a compensated work therapy program, a community residential care home if VA coordinated the placement; or a setting operated by a provider to whom VA provides grant and per diem funds, may be authorized medically necessary outpatient dental services.

For further information concerning VA dental eligibility or if you desire to make application to receive VA outpatient dental care, please contact the Health Administration Service or the appropriate official at the VA medical care facility in your area.

Sec. 10. Health Care Appeals: When a request for health care is received, VHA will provide when applicable, to the claimant or to the claimant's accredited representative a Veterans Claims Assistance Act Notice. If VHA denies the health benefit, the claimant will be notified in writing and provided appeal rights on VA Form 4107VHA, Your Right To Appeal Our Decision. The form advises the claimant of their rights to appeal the decision made, the time limits for filing an appeal, their rights to representation and all other pertinent facts relating to the appeal process. The claimant or the claimant's accredited representative may send a written statement disagreeing with a factual or legal conclusion made by VHA. The written statement will be considered a Notice of Disagreement (NOD). The NOD must be signed and dated by the claimant or the appointed representative. A NOD must be filed within 1 year from the date of the letter notifying the claimant of the denial decision. This begins the appeal process. VHA will then send the claimant and accredited representative a Statement of the Case (SOC) outlining the facts, pertinent laws and regulations, and the decision that was made, as well as a VA Form 9, Appeal to Board of Veterans' Appeals (BVA). The VA Form 9 must be submitted within 60 days to process the appeal timely. The claimant may request a hearing to present evidence to support the claim. Once the appeal is certified by the local health care facility, the complete package is submitted to the Chief Business Office, VA Central Office to be forwarded to BVA. From this point, the process is the same as any other VA appeal.

NOTE: The VFW does not represent appellants before the United States Court of Appeals for Veterans Claims, the Court of Appeals for the Federal Circuit or before the United States Supreme Court. VFW does not endorse any individual lawyer or law firm. However, we suggest that veterans seeking to appeal a BVA decision to the CAVC retain counsel to represent them. The Veterans Consortium Pro Bono Program at http://www.vetsprobono.org/ may provide representation at no cost.

Sec. 11. Veterans Health Identification Card: A Veterans Health Identification Card (VHIC) is issued to veterans for use at all VA health care facilities. Only veterans with verified eligibility will be issued a VHIC. The VHIC is a picture ID card with identifying information encoded on a magnetic strip and a bar code for use with some of the automated features available at some VA facilities. A VHIC is not required to obtain VA health care.

VA COMMUNITY CARE AND PURCHASED CARE PROGRAMS

Sec. 12. VA Purchased Care Programs: VA's Chief Business Office Purchased Care in Denver, Colorado, manages the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Spina Bifida (SB) Program, Children of Women Vietnam Veterans (CWVV) Program, and the Foreign Medical Program (FMP).

Veterans Community Care Program: According to the Mission Act of 2018, Veterans may be eligible for care through a provider in their local community depending on their health care needs or circumstances, and if they meet specific eligibility criteria. Even if a Veteran is eligible for community care, they generally still have the option to receive care from a VA medical facility.

Based on access standards:
- Drive time: 30 minute drive time for primary care, mental health and non-institutional care services.
- Drive time: 60 minute drive time for specialty care.
- Appointment wait time: 20 days for primary care, mental health and non-institutional care services.
- Appointment wait time: 28 days for specialty care.

In most cases, **Veterans must receive approval from VA** before receiving care from a community provider to avoid being billed for the care. VA staff members generally make all eligibility determinations for community care.

Veterans eligible for community care generally have the option of choosing to receive care from a VA medical facility or community provider. For Veterans who choice to receive community care, a VA staff member will discuss with them their preferences for getting care from a community provider.

Veterans can call the Community Care Call Center at 1-877-881-7618, if they are experiencing adverse credit or debt collection. More information about the program can be obtained at https://www.va.gov/COMMUNITYCARE/index.asp.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): A health benefits program under which the VA helps pay for covered medical services and supplies obtained from civilian sources by the spouse or child of a veteran who has a permanent and total service-connected disability, or by the surviving spouse or child of a veteran who dies as the result of a service-connected disability, or who at the time of death had a permanent and total service-connected disability. To be eligible for CHAMPVA benefits, the spouse or child cannot be eligible for benefits under the TRICARE Program.

CHAMPVA Coverage: CHAMPVA shares the cost of covered medical services (both inpatient and outpatient) and supplies with eligible beneficiaries worldwide that are medically necessary and appropriate for the treatment of a condition(s) that are not specifically excluded from program coverage.

Care not covered by CHAMPVA: Services specifically excluded from coverage include: Abortion or abortion counseling (except when the life of the mother would be endangered if the fetus were carried to term); chiropractic services; dental care; eye examinations (routine); eye glasses or contacts (coverage exceptions may apply); hearing exams (unless in connection with a covered illness/injury); routine physical exams and employment requested physicals; transportation services that do not require life sustaining equipment. Note: This list is not all inclusive.

Using CHAMPVA: CHAMPVA does not have a network of medical providers. However, most TRICARE and Medicare providers also accept CHAMPVA. When you go to a medical provider, present your CHAMPVA Authorization Card and find out if the provider will accept CHAMPVA. If the provider does not accept CHAMPVA, you can still see this provider; however, it is likely you will have to pay the entire charge at the time of service and submit your itemized bill to CHAMPVA for reimbursement. Reimbursement on the claim is based on the CHAMPVA allowable amount, less any cost share and deductibles.

Cost Sharing: CHAMPVA is a cost sharing program in which the cost of covered services is shared with the beneficiary. CHAMPVA pays the CHAMPVA determined allowable amount less the beneficiary deductible and cost share. The beneficiary cost share is 25% of the CHAMPVA determined allowable amount. The annual calendar year deductible is $50 for an individual or $100 for the family. For covered outpatient care after payment of a $50.00 individual or $100.00 family deductible, the CHAMPVA pays 75% of the remaining allowable charges. There is no deductible requirement for inpatient services, hospice, and pharmacy received through Meds by Mail. To provide financial protection against the impact of long term illness or injury, there is an annual catastrophic cap of $3,000 per family. Once the annual catastrophic cap is met, no further beneficiary cost share is required for that calendar year.

Other health insurance (OHI): CHAMPVA is a secondary or tertiary payer when OHI coverage exists. This includes Medicare. You or the provider must file the claim with the other health plan before submitting the claim to CHAMPVA for payment.

Applying for CHAMPVA Benefits: To apply for CHAMPVA benefits, an Application for CHAMPVA Benefits (VA Form 10-10d) must be submitted to: CHAMPVA, P.O. Box 469028 Denver, Co 80246-9028, or call (800) 733-8387 between the hours of 10:00 A.M. to 6:30 P.M. Monday-Friday Eastern Time.

To File a Claim. CHAMPVA claims may be submitted electronically or on a standard billing form (UB-04 – institutional or CMS-1500 – professional outpatient services) to VA Chief Business Office Purchased Care, CHAMPVA, PO Box 469064, Denver, CO 80246-9064. For outpatient claims, payment will be made to the provider unless the billing is accompanied by a completed and signed CHAMPVA Claim Form (VA Form 10-7959A). Only when this claim form is received with billing will payment be made to the beneficiary.

CHAMPVA Claim Filing Deadline: A formal claim, with supporting documentation, must be filed within one year of the date of the service provided or in the case of inpatient care, once year after the date of discharge.

CHAMPVA Appeals: Adverse decisions from CHAMPVA can be appealed by requesting a review of the decision in writing to Appeals, P.O. Box 460948, Denver, Colorado 80246-0948. For ChampVA guidebook visit https://www.va.gov/COMMUNITYCARE/docs/pubfiles/programguides/Caregiver_Program_Handbook.pdf.

Spina Bifida (SB) Program: VA provides monetary allowances, vocational training and rehabilitation and VA financed health care benefits to certain Korea and Vietnam Veterans' birth children who have been diagnosed with spina bifida. For the purposes of this program, spina bifida is defined as all forms or manifestations of spina bifida (except spina bifida occulta). The program covers comprehensive health care considered medically necessary and appropriate.

Spina Bifida Coverage: Coverage is no longer limited to the spina bifida condition. Spina bifida covers inpatient and outpatient health care services and supplies that are medically or psychologically necessary and appropriate for the treatment of covered medical condition(s) or complications. Spina bifida also covers ambulatory surgery and skilled nursing facilities when a skilled level of care is required, care in some health care facilities other than hospitals and outpatient clinics.

Care not covered by Spina Bifida: All services and supplies that are not medically necessary. Examples include: Abortion (unless the life of the mother would be endangered if the fetus were carried to term) or abortion counseling; eyeglasses or lenses; cosmetic surgery; dental care; and custodial care. Note: This list is not all inclusive.

Using Spina Bifida: Spina Bifida does not have a network of medical providers. Beneficiaries may select the provider of their choice, as long as the provider is an approved health care provider. The provider must be approved by the Centers for Medicare and Medicaid Services (CMS), Department of Defense TRICARE program, CHAMPVA, JCAHO or may be a health care provider approved for providing services pursuant to a state license or certificate.

Cost: There are no beneficiary co-payments or deductibles. VA is the exclusive payer for services provided to beneficiaries under this program. The determined allowable amount for payment is considered payment in full, and the provider may not bill the beneficiary for the difference between the billed amount and the VA-determined allowed amount.

Spina Bifida Enrollment: To be eligible for the Spina Bifida Health Care Program, you must first be eligible for a monetary award under the Veterans Benefits Administration (VBA). The Denver VA Regional Office makes the determination regarding that entitlement. The VBA notifies CHAMPVA after they have made a monetary award, and enrollment in the Spina Bifida Health Care Program is automatic.

To File a Claim: Spina bifida claims may be submitted electronically or on a standard billing form (UB-04 – institutional or CMS-1500 – professional outpatient services) to the VA Chief Business Office Purchased Care, PO Box 469065, Denver, CO 80246-9065. For out-of-pocket expenses, VA Form 10-7959E, (Claim for Miscellaneous Expenses) may be used for beneficiary submissions. Original receipts are required with the submission of this form.

Transportation expenses are authorized to and from approved health care providers within the reasonable commuting area. As a general rule, reasonable area would mean approximately a 50-mile radius from the beneficiary's residence to the location of treatment. Travel claims must be submitted on VA Form 10-7959E, along with receipts that reflect: certification of medical appointment, date of service, and place of service.

Spina Bifida Claim Filing Deadline: A formal claim, with supporting documentation, must be filed within one year of the date of the service provided or in the case of inpatient care, one year after the date of discharge.

Spina Bifida Appeals: Adverse decisions from Spina Bifida can be appealed by requesting a review of the decision in writing to Appeals, P.O. Box 460948, Denver, Colorado 80246-0948.

Children of Women Vietnam Veterans (CWVV): VA provides monetary allowances, vocational training and rehabilitation and VA-financed health care benefits to certain birth children of Women Vietnam Veterans identified by VA as one that is associated with the service of women Veterans in the Republic of Vietnam and that has resulted, or may result, in a permanent physical or mental disability for the child. The criteria for enrollment, claims filing, costs, and appeal process are the same as those for the Spina Bifida Program. The coverage of benefits under this program is limited to the birth defect itself only.

Camp Lejeune Family Members: From the 1950s through the 1980s, people living or working at the U.S. Marine Corps Base Camp Lejeune, North Carolina were potentially exposed to drinking contaminated with industrial solvents, benzene, and other chemicals.

VA health care benefits are available to veterans and family members who lived at Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987.

Eligible family members receive reimbursement for out-of-pockets medical expenses incurred from treatment of qualifying health conditions after all other health insurance is applied.

How to apply as a family member: Family members may apply on-line for medical reimbursement at: https://www.clfamilymembers.fsc.va.gov/ or by completing a paper application VA Form 10-10068 and mail to: Department of Veterans Affairs Financial Services Center; PO Box 149200, Austin, TX 78714-9200. For questions about the program call: 866-372-1144.

Health Care for Camp Lejeune Veterans: Veterans who have one or more of the qualifying health conditions should enroll in VA Health Care. Veteran will qualify for Priority Group 6 enrollment and the full VA medical Benefits Package.

Veterans may also apply for service-connected compensation for any disability they believe is related to their exposure to the contaminated water. These cases will be decided on a case-by-case basis. VA has established presumptive service connection for (Adult leukemia, Aplastic anemia and other myelodysplastic syndromes, Bladder cancer, Kidney cancer, Liver cancer, Multiple myeloma, Non-Hodgkin's lymphoma, and Parkinson's disease) conditions caused by exposure to this contaminated water. For updates on toxic exposures at Camp Lejeune and other locations, and related VA benefits, please visit: https://www.publichealth.va.gov/ .

Foreign Medical Program (FMP): The FMP is a health care benefits program for U.S. veterans with a VA-rated, service connected condition(s) who are living or traveling abroad. The eligibility requirements for medical services for veterans outside the United States are different than those for veterans within the United States. VA may authorize foreign medical services for veterans only for a VA-rated, service connected condition or for a condition that is associated with and aggravated by a VA-rated, service connected condition. This means that medical services that are available to veterans on the basis of their percentage of VA disability within the United States *do not apply* when determining eligibility for foreign medical services.

Additionally, under the FMP Program, VA may authorize necessary foreign medical services for any condition for a veteran participating in the VA Vocational Rehabilitation Program (title 38 U.S.C. Chapter 31).

Care not covered by FMP: Services specifically excluded from coverage include: Services, treatment, prescriptions unrelated to the service connected condition; custodial care, DME with deluxe/luxury features, dental care (unless service connected), services that are not accepted by the VA and or US medical community, non-FDA approved drugs. This list is not all inclusive.

Using FMP: Authorization in advance of obtaining FMP health care services is not necessary. Veterans who have established permanent residence in a country other than the Philippines are encouraged to notify the FMP office of their current address. To register for FMP authorization, applicants need only submit a written request with the following information: veteran's name, mailing address, telephone and fax numbers (if available), US social security number, VA claim number and veterans (or fiduciary's) signature and date. Notification can be made at the following address: VA Chief Business Office Purchased Care, Foreign Medical Program, PO Box 469061, Denver, CO 80246-9061, USA. At that time, arrangements will be made for the FMP registration and the mailing of program material. The VA Chief Business Office Purchased Care has no jurisdiction over health care services received in the Philippines. To obtain information on these services, including procedures for filing claims, contact: VA Outpatient Clinic (358/00), 2201 Roxas Blvd., Pasay City 1300, Republic of the Philippines.

FMP Claims: You may elect to choose any health care provider who is licensed to provide the medical services you require. You may pay the provider and then file a claim by submitting the bill, medical documentation and proof of payment to the FMP office (see address above). Or your provider may submit the bill and medical documentation for FMP payment.

Sec. 13. Non-VA Care at VA Expense: The following provisions apply to both hospital and outpatient treatment:

Prior Authority: VA is not authorized to pay expenses or costs in connection with medical care, including hospitalization, outpatient treatment, dentistry, and transportation, in a non-VA facility unless such treatment was given prior VA approval. An exception is emergency care.

Emergency Care – Service-connected: VA may assume cost of emergency treatment in a private hospital when VA facilities are not available for service-connected disability and any disability of a veteran who has total and permanent disability from a service-connected disability provided notice thereof is given to the VA within the first 72 hours of treatment.

The expense of cost of unauthorized outpatient treatment for service-connected disability also may be assumed by the VA, provided such treatment was emergent.

Reimbursement: VA may assume responsibility for payment of private medical care, which was not previously authorized, only when all of the following criteria have been met:

(1) Treatment was provided for a service-connected disability or a non-service-connected disability held to be associated with or aggravating a service-connected disability, and/or any patient who is rated as permanent and total as adjudicated by VBA;

(2) Care and services were rendered in a medical emergency; and

(3) VA or other federal medical facilities were not feasibly available and an attempt to use them beforehand would not have been reasonable or practical. In the absence of any one of these three conditions, the VA cannot assume payment or reimbursement for the cost incurred for private medical care.

(4) Claims for payment or reimbursement of the expenses of medical care or services not previously authorized must be filed within the following time limits:

(a) A claim must be filed within 2 years after the date the care or services were rendered (and in the case of continuous care, payment will not be made for any part of the care rendered more than 2 years prior to filing claim), or

(b) In the case of case or services rendered prior to a VA adjudication allowing service-connection:

(1) The claim must be filed within 2 years of the date the veteran was notified by VA of the allowance of the award of service-connection.

(2) VA payment may be made for care related to the service-connected disability received only within a 2-year period prior to the date the veteran filed the original or reopened claim which resulted in the award of service-connection but never prior to the effective date of the award of service-connection within that 2-year period.

(3) VA payment will never be made for any care received beyond this 2-year period whether service connected or not.

Emergency Care – Nonservice-connected: VA may pay for emergency care rendered for a veteran's nonservice-connected conditions in non-VA facilities if the veteran is enrolled in the VA health care system and has no other source of payment for the care.

Reimbursement: VA may assume responsibility for payment of emergency non-VA medical care only when **all** of the following criteria have been met:

(1) The veteran must have been enrolled in the VA healthcare system and received care from the VA within 24 months prior to the emergency care; and

(2) Care and services were rendered in a medical emergency; and

(3) VA or other federal medical facilities were not feasibly available and an attempt to use them beforehand would not have been reasonable or practical; and

(4) The veteran has no health insurance coverage and is solely liable for the full cost of the emergency care. (If partial payment is made by another payer, VA cannot make any reimbursement); Public Law 111-137 amends 38 U.S.C. 1725 by changing the definition of personal liability by removing the disqualifying factor of payment in part by a third party payer, and removing one's own automobile reparations coverage from the definition of a health plan contract (a/k/a personal injury protection provisions in automobile insurance policies), and

(5) The care is rendered by an emergency care facility that normally provides emergency care to the public; and

(6) The claim is filed within 90 days of the date of the emergency care or 90 days from when all attempts to recover the costs of treatment from other health care payers has been exhausted.

In the absence of any one of these six conditions, VA cannot assume payment or reimbursement for the cost incurred for private medical care.

Foreign Country: VA may assume responsibility for necessary hospital care and medical services provided to a veteran who is a US citizen and is otherwise eligible to receive hospital care and medical services if the VA determines that such care and services are needed for the treatment of a service-connected disability of the veteran or as part of a rehabilitation program under chapter 31. Eligible veterans will receive a Foreign Medical Program (FMP) authorization identifying his/her VA rated service-connected condition(s). The authorization will provide certification that VA will assume payment responsibility for all foreign provided medically necessary services that are accepted by the VA/US medical community and are directly related to the treatment of the identified service-connected condition(s). Service-connected veterans living or traveling overseas must register with the Foreign Medical Program regardless of the degree of disability to receive VA health care benefits for their service-connected conditions while outside the United States. To apply for FMP authorization, applicants need only submit a written request with the following information: Veteran's name, mailing address, telephone and fax numbers (if available), US social security number, VA claim number and veteran's (or fiduciary's) signature and date at the following address, FMP office, PO Box 469061, Denver CO 80246-9061. More information about the FMP may be obtained at https://www.va.gov/COMMUNITYCARE/programs/veterans/fmp/index.asp, and by telephone (local) at: (303) 331-7590.

Not covered by FMP (this list is not all inclusive): FMP has no jurisdiction over health care services rendered in the Philippines. To obtain information on services in that country, contact the respective office at VA Outpatient Clinic, 2201 Roxas Blvd., Pasay City 1300, Republic of the Philippines.

The reimbursement of services, treatment, and prescriptions that are unrelated to the service-connected disability or are considered to be experimental or investigational are not covered.

FAMILY CAREGIVER PROGRAM

Sec. 14. VA Program of Comprehensive Assistance for Family Caregivers (PCAFC): This caregiver program is a change based on the amendments under the MISSION Act of 2018. The program provides beneficiary travel, education, a financial stipend, health insurance, mental health counseling, resources, and support to eligible caregivers of eligible veterans. Veterans eligible for this clinical program are those that have incurred, sustained, or aggravated a serious injury in the line-of-duty or have a serious illness on or before May 7, 1975, or on or after September 11, 2001. Information and details about the program and applicable eligibility criteria for veterans and caregivers can be found using the following link:

https://www.caregiver.va.gov/pdfs/MIssionAct/EligibilityCriteriaFactsheet_Chapter2_Launch_Approved_Final_100120.pdf#

Participation in the PCAFC is via a joint application (veteran and caregiver) using one of the three methods listed below:

Online: https://www.va.gov/family-member-benefits/apply-for-caregiver-assistance-form-10-10cg/introduction
By Mail: Send application forms (VA Form 10-10CG) and any supporting documents to:

Program of Comprehensive Assistance for Family Caregivers
Health Eligibility Center
2957 Clairmont Road NE, Suite 200
Atlanta, GA 30329-1647

In-Person: Take completed VA Form 10-10CG and other documents to the local VA Medical Center's Caregiver Support Coordinator.

Note: To request assistance completing the application or to check the status of the VA Form 10-10CG call 1-855-488-8440, option 3.

HOMES AND DOMICILIARIES

Sec. 15. VA Domiciliary Care: This program represents a distinct component of the Department of Veterans Affairs (VA) comprehensive continuum of health care services. Two distinct types of care are offered in Domiciliaries - short-term active biopsychosocial rehabilitation and long-term health maintenance care. This program is also a clinically appropriate level of care for the homeless veteran whose clinical needs are not severe enough to require more intensive levels of treatment.

In a therapeutic home-like environment, the Domiciliary Care Program provides active residential rehabilitation directed toward development of the skills necessary for return to community-based living. Clinical interventions are intended to provide optimal opportunity for community interaction, vocational involvement and graduated independence not available at other levels of care. The Domiciliary Care Program's clinical interventions build on the strengths of the veteran, enhance quality of life experiences and maximize potential for independent functioning.

Criteria for admission: A VA physician will determine the medical need of the patient. To be found clinically eligible for admission to the VA's Domiciliary Care Program, an applicant must: (1) present impairment(s) of mind and/or body sufficient in degree to cause a qualified physician to determine that care in an institutional setting is essential to the effective provision of necessary health care services; (2) remain for at least a period of time unable to pursue substantially gainful employment; and (3) be currently unable to provide adequately for self in the community.

Income equal or greater than the prevailing pension rate plus aid and attendance will be considered *prima facie* evidence of adequacy of support. This is subject to rebuttal by a showing that income is not adequate to provide the care required by reason of disability or that the income is not available for use because of other obligations such as contributions in whole or in part to the support of a spouse, child, mother, or father.

An additional requirement for domiciliary care is the ability of the veteran to:

- Accomplish activities of daily living with minimal assistance.
- Receive clinical care on an ambulatory basis or by use of self-managed wheelchair or other assisted devices.
- Actively participate in prescribed treatment, rehabilitation and/or health maintenance activities.
- Make rational and competent decisions to remain in or to leave the domiciliary.
- Share by personal effort, in some measure, as part of a therapeutic program, in the maintenance and operation of the health care facility. Patients assume responsibility for the housekeeping of life space in the living unit to which assigned.
- Maintain appropriate, self-directed behaviors and freedom from behaviors that would constitute a danger to self or others.
- Handle full privileges and authorized absences as deemed therapeutically appropriate.
- Be free of active substance abuse.

Legally blind veterans meeting all other admission criteria will be admitted if they have completed mobility training at a VA Blind Rehabilitation Center or equivalent program. If the veteran has not had such training, referral should be made to the nearest VA Blind Rehabilitation Center or clinic for admission to such training. Contact should be made with the Chief of the VA Blind Rehabilitation Program concerning referral of the veteran(s).

Patient applicants for admission must clearly demonstrate motivation for rehabilitation and/or health maintenance services.

Sec. 16. Hospital Care and Medical Services in Non-VA Facilities: When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, will only be authorized, whether under a contract or an individual authorization, for:

A. Hospital care or medical services to a veteran for the treatment of:
   1. A service-connected disability; or
   2. A disability for which a veteran was discharged or released from the active military, naval, or air service; or
   3. A disability of a veteran who has a total disability permanent in nature from a service-connected disability; or
   4. For a disability associated with and held to be aggravating a service-connected disability, or

5. For any disability of a veteran participating in a rehabilitation program and when there is a need for hospital care or medical services.

B. Medical services for the treatment of any disability of:
   1. A veteran who has a service-connected disability rated at 50 percent or more;
   2. A veteran who has received VA inpatient care for treatment of nonservice-connected conditions for which treatment was begun during the period of inpatient care. The treatment period (to include care furnished in both facilities of VA and non-VA facilities or any combination of such modes of care) may not continue for a period exceeding 12 months following discharge from the hospital except when it is determined that a longer period is required by virtue of the disabilities being treated.

C. Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

D. Hospital care for women veterans;

E. Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less than 181 days.

F. Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense).

G. Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission.

H. For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non-VA facilities.

NOTE: The Under Secretary for Health shall only furnish care and treatment to the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans in VA facilities.

Sec. 17. Foster Homes: Medical Foster Homes are private homes in which a trained caregiver provides services to a few individuals. Some, but not all, residents are Veterans. VA inspects and approves all Medical Foster Homes. Medical Foster Homes are not provided or paid for by VA. To be eligible for a Medical Foster Home you need to be enrolled in Home Based Primary Care, and a Home needs to be available. Your VA social worker or case manager can help you with eligibility guidelines for Home Based Primary Care and Medical Foster Home care.

Sec. 18. Armed Forces Retirement Home: Public Law 101-510, *The Armed Forces Retirement Act of 1991*, merged the United States Soldiers and Airmen's Home in Washington, DC and the United States Naval Home in Gulfport, Mississippi into one program with management and oversight authority given to the newly establish Armed Forces Retirement Home Control Board. A director who is responsible for day-to-day operations will supervise each home.

Requirements: The law requires that at least one-half of the residents be enlisted personnel, warrant officers or, for the Navy, limited duty officers; residents must be free from alcohol, drugs and psychiatric problems, never convicted of a felony and able to live independently in a self-care environment.

Eligibility: The following persons who served as members of any armed forces branch are eligible to become residents of the retirement homes:

- Category 1: 60 years of age or over, and were discharged or released from service in the armed forces under honorable conditions after 20 or more years of active service.
- Category 2: Veterans determined to be incapable of earning a livelihood because of service-connected disability.
- Category 3: Veterans who served in a war theater during a time of war declared by Congress or were eligible for hostile fire special pay under section 310 of title 37 United States Code; were discharged or released from service under honorable conditions; and determined to be incapable of earning a livelihood because of injuries, disease or disability.

- Category 4: Veterans who served in a women's component of the Armed Forces before the enactment of the Women's Armed Services Integration Act of 1948 and are determined to be eligible for admission because of compelling personal circumstances.

For additional information or to obtain an admission application package, veterans can contact or visit one of the Armed Forces homes at the following address:

Armed Forces Retirement Home
3700 N. Capitol Street NW
Washington, DC 20011-8400
(800) 422-9988
admissions@afrh.gov

Armed Forces Retirement Home
1800 Beach Drive
Gulfport, MS 39507
(800) 422-9988
admissions@afrh.gov

Sec. 19. State Veterans Homes: Following the Civil War, a large number of indigent and disabled veterans were no longer able to earn their own livelihood and needed care. While the Federal Government operated national homes for disabled union volunteer soldiers, the total number of veterans needing care was overwhelming. In recognition of this, a number of states independently established State Veterans Homes (SVHs). The first State Veterans Home was established in Rocky Hill, Connecticut in 1864.

There are fifty states and Puerto Rico operating homes for veterans. State homes are established by a State for veterans disabled by age, disease, or otherwise, who by reason of such disability are incapable of earning a living. The home provides quality of care for eligible veterans in need of domiciliary, nursing home, hospital, and adult day health care. When a State home accepts VA construction grant assistance, at least 75 percent of the bed occupants at any one time at the facility must be veterans. As a goal, VA plans to maintain at least a 33 1/3 percent share of the States' cost for the provision of such care. VA will also continue to encourage States to construct and renovate State homes to provide needed new beds and to maintain a safe and healthy environment in existing State veterans homes for eligible veterans seeking long term care.

Usually, state residency for a period of time prior to admission is mandatory, otherwise rules of admission vary greatly from state home to state home. In some states, non-veterans such as spouses, widows or gold-star parents may be admitted. For more information, please go to: http://www.nasvh.org/.

The VA is authorized to pay a state for the care of an eligible veteran who is maintained in a state home. Payment shall not exceed one-half of the cost of maintenance.

Sec. 20. VFW National Home: The National Home is true to its original goal of providing love, care and education for the widows and children of members of the Veterans of Foreign Wars and its Auxiliary. In its 90 years of service, the Home has provided a stable growing environment to hundreds of these youngsters. Today's program continues to respond in a creative way to the special needs of these children and families.

The National Home campus has been developed as a 50-acre segment of the VFW's 630-acre property near Eaton Rapids, Michigan. Single-family homes built by various VFW departments provide normal living environments within what seems to be a small suburban neighborhood. Children live in groups that vary in number (3-6) and age range. Trained house-parents are the primary caregivers and are supported by maintenance, transportation, office and professional staff.

Program Components include: Long and short-term group care, depending on the needs of the children and families; education in the public schools with tutorial help at the National Home for those with special learning needs; church involvement in the community; diverse recreational opportunities on and off campus; counseling and psychological testing; work programs; family outreach services; and extensive scholarship help for graduates wishing to attend college or trade schools.

Admissions: The Home accepts individual children (infant to age 18) and sibling groups. While some are true orphans, many come from fragmented and chaotic homes where they may have experienced abuse and neglect. Some come with mild to moderate behavior and/or learning problems. The Home cannot presently serve those with serious emotional, physical or intellectual disabilities.

In a unique aspect of the program, the Home also accepts entire family units headed by a single parent. Families experiencing the emotional and financial hardships accompanying death, disability, divorce or other family breakdown may need the supportive environment of the Home to help them reunite and/or strengthen their family.

Eligibility: Eligibility requirements reflect the desire to continue being of service to VFW families. Shortening the time requirements for membership ensures that children and families can be helped without prior active parental involvement in the VFW or Auxiliary. The four categories, in order of priority, are:

(1) A child whose parent is deceased or totally disabled, providing the deceased or totally disabled parent is a member in good standing of the VFW of the US.

(2) A child whose parent is deceased or totally disabled and the living or non-disabled parent is a member in good standing of the VFW or the Auxiliary to the VFW.

(3) A child whose parent or grandparent is a member in good standing of the VFW or the Auxiliary to the VFW and the grandparent or grandparents have a legal custody of the child.

(4) A child whose parent is a member in good standing of the VFW or the Auxiliary to the VFW and the home study investigation by national Home staff reveals that the home situation is not conducive to the physical and emotional health of the child.

Service Officers can be most effective by calling with any questions regarding eligibility or procedure (1-800-851-0238) knowing the family situations of Post and Auxiliary members, and working with local social service personnel to identify children and families who can use the Home's service and who would be eligible for admission under the expanded categories. Follow this by having the responsible parent join the VFW or Auxiliary, if not already a member. At that instant, they and/or their children become eligible to come to the National Home. For further information, contact:

VFW National Home
3573 S. Waverly Road
Eaton Rapids, MI 48827
(800) 424-8360 or 1-866-483-9642 (Monday – Friday: 8am – 4:30pm EST)
http://www.vfwnationalhome.org/
info@vfwnationalhome.org

VA VOLUNTARY SERVICE

Sec. 21. Department of Veterans Affairs Voluntary Service Program (VAVS): Through the Department of Veterans Affairs Voluntary Service (VAVS) Program, the Veterans of Foreign Wars (VFW), other service organizations and civic and fraternal groups provide direct and indirect volunteer service to patients in VA facilities.

The National VAVS Advisory Committee is composed of National Representatives and Deputy National Representatives of service and welfare organizations, including the VFW. The committee meets annually to discuss subjects and problems of mutual interest and to submit recommendations for improvement of the program for consideration by VA officials. Committee work is carried on during the year through subcommittee and study groups composed of members of the National Committee with representatives from the VA Central Office staff.

The National Veterans Service of the VFW is the National authorized certifying official. In addition, to the National VFW VAVS representative, one member of the National Veterans Service staff serves as Deputy National VFW VAVS representative. Department Commanders recommend to the National Authorized Certifying Official appointment of qualified, interested members who can attend committee meetings with reasonable regularity, as VFW representatives and Deputy VFW representatives on Department of Veterans Affairs Medical Center (VAMC) VAVS committees.

The James H. Parke Memorial Youth Scholarship Award, comprised of VAVS National Advisory Committee (NAC) member organizations, was established in 1976 to serve as the non-profit source of funds for a VAVS youth scholarship. Organizations, volunteers, VA staff and others continue to contribute to the fund. Based on the funds available, the selection committee picks a number of outstanding youth volunteers from those submitted. One of those selected will be chosen to receive recognition as the national outstanding youth volunteer. Any youth who has not attained the age of 20 by August 15 and who has volunteered a minimum of 100 hours at a VA facility during the period January 1st to August 15th of the nominating year may be nominated. Information on this award can be secured from the Chief of Voluntary Service at the nearest VA medical facility or from the Director, National Veterans Service.

VA FACILITY LOCATOR

Sec. 22. VA Facility Locator: The following link can be used to identify the nearest VA facility, to include VA Medical Centers, VA clinics, VA Regional Offices, Vet Centers, and contracted Community Care clinics:

https://www.va.gov/find-locations/

Sec. 23. List of VA Medical Centers: A listing of location of VA Medical Centers with links to each facility's web site, to include direct contact directories, leadership information, and social media platforms may be found at: https://www.va.gov/health/vamc/, or by calling 1-844-698-2311.

NO ONE DOES MORE FOR VETERANS®

Veterans of Foreign Wars of the United States

www.vfw.org