OMB Number: 2900-0629
Estimated Burden: 90 min.
Expiration Date: 04/30/2025

Department of Veterans Affairs

# INSTRUCTIONS FOR COMPLETING APPLICATION FOR EXTENDED CARE SERVICES *(VAF 10-10EC)*

**STEP 1. Before You Start. . . .**

**What is VA Form 10-10EC used for?**

To determine the estimated amount of your monthly copayment obligations for extended care services provided to you by VA, either directly by VA or paid for by VA. There is no copayment for the first 21 days of extended care services that VA provides to you in any 12 month period. You must report any changes that might affect the copayment amount to your local VA medical facility within 10 calendar days of the change.

**Where can I get help filling out the form?**

Contact the Social Work staff at your local VA medical facility for assistance on understanding the information and financial data needed to complete VA Form 10-10EC.

**What will I need to know in order to complete the form?**

Current income of both veteran and spouse *(can report monthly or annual income).*
Current deductible expenses *(can report monthly or annual expenses). For example property taxes may be reported as an annual amount.*
Value of fixed and liquid assets of both veteran and spouse. See Section IV of these instructions for further information regarding the reporting of assets.
All health insurance information covering you even if it is through your spouse *(a copy of your insurance card).*
Medicare information *(Part A & Part B) (a copy of your Medicare card).*
Spousal/Dependent information *(including spouse's social security number, dependents date of birth).*

**STEP 2. Completing the application . . . .**

**Section I - General Information.** Include your name and full social security number.

**Section II - Insurance Information.** Include information for Medicare and all health insurance companies that cover you. It is important that we obtain all health insurance coverage for you *(including coverage through a spouse).* Please make a copy of your Medicare card and all health insurance cards and include them with this completed application.

**Section III - Spouse/Dependent Information.** In order to determine if a veteran must pay an extended care copayment amount, it is necessary to identify spousal and/or dependent information and whether they are residing in the community *(not institutionalized).* A spouse or dependent is considered institutionalized if they are residing in a nursing home or hospital setting. A dependent other than spouse would be son, daughter, stepson, or stepdaughter. Provide address and phone number of spouse or dependent if different from the veteran. Report current marital status. **Do not include spousal information if you and spouse are legally separated or divorced.** If you are certifying that a person is your spouse for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse reside when you file your claim (or at a later date when you become eligible for benefits) (38 U.S.C. 103(c)). Additional guidance on when VA recognizes marriages is available at **http://www.va.gov/opa/marriage/.**

**Section IV - Fixed Assets.** Used only in the determination of the extended care copayment amount when a veteran reaches 181 days or more of institutional *(inpatient)* extended care services.

**Report** real property minus any outstanding lien or mortgage.

**Exclude** burial plots, veteran's primary residence and veteran's vehicle (if the veteran is receiving institutional (*inpatient*) extended care services this is the primary residence and vehicle of the spouse or dependents).

**Section V - Liquid Assets.** Used only in the determination of the extended care copayment amount when a veteran reaches 181 days or more of institutional *(inpatient)* extended care services.

**Report** cash, stocks, dividends received from IRA, 401K's and other tax deferred annuities, bonds, mutual funds, retirements accounts (e.g. IRA, 401Ks, annuities), art, rare coins, stamp collections, and other collectibles.

**Exclude** household and personal items such as furniture, clothing and jewelry if the veteran has a spouse or dependents residing in the community.

If the veteran has a spouse residing in the community (not institutionalized), the spousal resource protection amount may be applied to reduce the value of liquid assets.

**Section VI - Current Gross Income of Veteran and Spouse.** Do not include income from dependents.

**Report** wages, bonuses, tips, severance pay and accrued benefits

**Report i**ncome from a business (minus business expenses)

**Report** cash gifts, inheritance amounts, intrest income, and the standard dividend income from non tax deferred annunities.

**Report** retirement income and pension income.

**Report** unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, and court mandated payments.

**Report** payments from VA or any other Federal programs, and any other income.

**Exclude** income of the Veteran's dependents.

**Section VII. Expenses.** Not used in the determination of the extended care copayment amount when a veteran reaches 181 days or more of institutional *(inpatient)* extended care services and does not a have a spouse or dependents residing in the community (not institutionalized).

**Report** basic subsistence (living) expenses.

**Include** any educational expense incurred by the veteran, spouse or dependent.

**Include** any funeral or burial expenses for your spouse or dependent as well as any prepaid funeral or burial arrangements for yourself, spouse, or dependent.

**Include** rent or mortgage payment for primary residence only.

**Include** amount paid for utilities *(electricity, gas, water or phone)*. You can calculate the amount by using the average monthly expenses during the past year for your utilities.

**Include** car payment for one vehicle only.

**Include** amount spent for food for veteran, spouse or dependent.

**Include** non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, medications, eyeglasses, Medicare, medical insurance premiums, medical copayments and other hospital or nursing home expense.

**Include** court ordered payments such as alimony or child support.

**Include** insurance premiums such as automobile and homeowners. Exclude life insurance premiums.

**Include** taxes paid on property and average monthly expense for taxes paid on income over the past 12 months.

**STEP 3. Submitting your application**

**What do I do when I have finished my application?**

1. Read Section VIII, Consent for Assignment of Benefits, Section IX, Consent to Agreement to Make Copayments, and Section X, Privacy Act and Paperwork Reduction Act Information.

2. In Section VIII and Section IX, you or an individual to whom you have delegated your Power of Attorney must sign and date.

3. Attach any documentation such as copies of Medicare and other health insurance cards, and your Power of Attorney documents to your application.

4. Return the original form and supporting documentation to the Social Work staff at your local VA medical facility.

**STEP 4. Finding out what my Extended Care Copayment Amount will be.**

Once the VA Form 10-10EC is completed, the Social Work staff at your local VA medical facility will counsel you, or an individual to whom you have delegated your Power of Attorney, on your estimated monthly copayment obligations for the requested extended care services.

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# APPLICATION FOR EXTENDED CARE SERVICES

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation. (See 18 U.S.C. 287 and 1001)

## SECTION I - GENERAL INFORMATION

| 1. VETERAN'S NAME *(Last, First, MI)* | 2. SOCIAL SECURITY NUMBER |
|---|---|
| | |

## SECTION II - INSURANCE INFORMATION

**ANSWER YES OR NO WHERE APPLICABLE *(OTHERWISE PROVIDE THE REQUESTED INFORMATION)***

| 3. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO | 3A. ARE YOU ENROLLED IN MEDICARE PART A *(Hospital Insurance)* ☐ YES ☐ NO | 3B. EFFECTIVE DATE *(If "Yes")* |
|---|---|---|
| | | |

| 4. NAME OF INSURANCE COMPANY | 4A. ADDRESS OF INSURANCE COMPANY | 4B. PHONE NUMBER OF INSURANCE COMPANY |
|---|---|---|
| | | |

| 4C. NAME OF POLICY HOLDER | 4D. RELATIONSHIP OF POLICY HOLDER | 4E. POLICY NUMBER | 4F. GROUP NAME AND/OR NUMBER |
|---|---|---|---|
| | | | |

## SECTION III - SPOUSE/DEPENDENT INFORMATION

| 5. CURRENT MARITAL STATUS *(Check one)* ☐ LEGALLY SEPARATED ☐ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED | 5A. SPOUSE'S NAME *(Last, First, MI)* |
|---|---|
| | |

| 5B. SPOUSE RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)* ☐ YES ☐ NO *(If "No", explain)* | 5C. SPOUSE'S SOCIAL SECURITY NUMBER |
|---|---|
| | |

| 6. DEPENDENT'S NAME *(Last, First, MI)* | 6A. DEPENDENT'S DATE OF BIRTH | 6B. DEPENDENT'S SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

6C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)*
☐ YES ☐ NO *(If "No", explain)*

| 7. DEPENDENT'S NAME *(Last, First, MI)* | 7A. DEPENDENT'S DATE OF BIRTH | 7B. DEPENDENT'S SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

7C. DEPENDENT RESIDING IN THE COMMUNITY? *(Provide address and phone number if different from veteran)*
☐ YES ☐ NO *(If "No", explain)*

We need to collect information regarding income, assets and expenses for you and your spouse. If you do not wish to provide this information you must sign agreeing to make copayments and will be charged the maximum copayment amount for all services. See the top of page 2, read, sign and date.

## APPLICATION FOR EXTENDED CARE SERVICES, Continued

| VETERAN'S NAME | SOCIAL SECURITY NUMBER |
|---|---|
| | |

I do not wish to provide my detailed financial information. I understand that I will be assessed the maximum copayment amount for extended care services and agree to pay the applicable VA copayment as required by law.

| SIGNATURE *(Sign in ink)* | DATE |
|---|---|
| | |

| SECTION IV - FIXED ASSETS *(VETERAN AND SPOUSE)* | VETERAN | SPOUSE |
|---|---|---|
| 1. Primary Residence (Market value minus mortgages or liens. *Exclude if veteran receiving only non-institutional extended care services or spouse or dependent residing in the community). If the veteran and spouse maintain separate residences, and the veteran is receiving institutional (inpatient) extended care services, include value of the veteran's primary residence.)* | $ | $ |
| 2. Other Residences/Land/Farm or Ranch *(Market value minus mortgages or liens. This would include a second home, vacation home, rental property.)* | $ | $ |
| 3. Vehicle(s) *(Value minus any outstanding lien. Exclude primary vehicle if veteran receiving only non-institutional extended care services or spouse or dependent residing in community. If the veteran and spouse maintain separate residences and vehicles, and the veteran is receiving institutional (inpatient) extended care services, include value of the veteran's primary vehicle.)* | $ | $ |
| **SECTION V - LIQUID ASSETS *(VETERAN AND SPOUSE)*** | | |
| 1. Cash, Amount in Bank Accounts *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds).* | $ | $ |
| 2. Value of Other Liquid Assets *(e.g., art, rare coins, stamp collections, collectibles) Minus the amount you owe on these items. Exclude household effects, clothing, jewelry, and personal items if veteran receiving only non-institutional extended care services or spouse or dependent residing in the community.* | $ | $ |
| **SUM OF ALL LINES FIXED AND LIQUID ASSETS** **TOTAL ASSETS** | $ | $ |

**SECTION VI - CURRENT GROSS INCOME OF VETERAN AND SPOUSE**

| CATEGORY | VETERAN | | SPOUSE | |
|---|---|---|---|---|
| | HOW MUCH | HOW OFTEN | HOW MUCH | HOW OFTEN |
| 1. Gross annual income from employment *(e.g., wages, bonuses, tips, severances pay, accrued benefits)* | $ | | $ | |
| 2. Net income from your farm/ranch, property or business. | $ | | $ | |
| 3. List other income amounts *(e.g., social security, Retirement and pension, interest, dividends)* Refer to instructions. | $ | | $ | |

**SECTION VII - DEDUCTIBLE EXPENSES**

| ITEMS | AMOUNT |
|---|---|
| 1. Educational expenses of veteran, spouse or dependent *(e.g., tuition, books, fees, material, etc.)* | $ |
| 2. Funeral and Burial *(spouse or child, amount you paid for funeral and burial expenses, including prepaid arrangements)* | $ |
| 3. Rent/Mortgage *(monthly amount or annual amount)* | $ |
| 4. Utilities *(calculate by average monthly amounts over the past 12 months)* | $ |
| 5. Car Payment for one vehicle only *(exclude gas, automobile insurance, parking fees, repairs)* | $ |
| 6. Food *(for veteran, spouse and dependent)* | $ |
| 7. Non-reimbursed medical expenses paid by you or spouse *(e.g., copayments for physicians, dentists, medications, Medicare, health insurance, hospital and nursing home expenses)* | $ |
| 8. Court-ordered payments *(e.g., alimony, child support)* | $ |
| 9. Insurance *(e.g., automobile insurance, homeowners insurance) Exclude Life Insurance* | $ |
| 10. Taxes *(e.g., personal property for home, automobile) Include average monthly expense for taxes paid on income over the past 12 months.* | $ |
| **TOTALS** | $ |

## APPLICATION FOR EXTENDED CARE SERVICES, Continued

### SECTION VIII - CONSENT FOR ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

| SIGNATURE *(Sign in ink)* | DATE |
|---|---|
| | |
| VETERANS NAME | SOCIAL SECURITY NUMBER |
| | |

### SECTION IX - CONSENT TO AGREEMENT TO MAKE COPAYMENTS

Completion of this form with signature of the Veteran or veteran's representative is certification that the veteran/representative has received a copy of the Privacy Act Statement and agrees to make appropriate copayments.

l declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge and I agree to make the applicable copayment for extended care services as required by law. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001.

| SIGNATURE *(Sign in ink)* | DATE |
|---|---|
| | |

### SECTION X - PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

The VA is asking you to provide the information on this form under Title 38, United States Code, sections 1710, 1712, 1722 and 1729 for VA to determine your eligibility for extended care benefits and to establish financial eligibility, if applicable, when placed in extended care services. Obligation to respond is voluntary. The information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law; possible disclosures include those described in the "routine use" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 90 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ADDITIONAL COMMENTS: