VA Health Care Overview

Department of Veterans Affairs

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building on over 50 years of providing quality health care services to our nation's veterans

This guide is designed to provide veterans and their families with the information they will need to understand VA's health care system—its enrollment process including enrollment priority groups, required copayments, if applicable, and what services are covered. In addition to a narrative description, we have also added frequently asked questions to each segment. If we have not addressed your specific questions, additional help is available at the following sources.

- your local VA health care facility's Enrollment Office
- the eligibility page on our web site **www.va.gov/elig**
- Veterans Health Benefits Service Center **1-877-222-VETS (8387)**

OVERVIEW

Over time, VA health care has changed significantly. In recent years, legislative changes have dramatically enhanced veterans' health care benefits as well as access to those benefits. Today's veterans have a comprehensive benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure that health care benefits are readily available to all enrolled veterans (see Enrollment Priority Groups on page 7).

Complementing the expansion of benefits and improved access is our ongoing commitment to providing the very best in quality service. Our goal is to ensure that our patients receive the finest quality of health care regardless of the treatment program, regardless of the location. In addition to our ongoing quality assurance activities, we've made it easier for veterans to get the health care they need. Additional locations continue to be added to the VA health care system—bringing the total number of treatment sites to over 1,600 nationwide.

As explained further in this guide, most veterans must be enrolled to receive VA health care. While some veterans are not required to enroll due to their special eligibility status, all veterans—including those who have special eligibility—are encouraged to apply for enrollment. Enrollment helps us to determine the number of potential veterans who may seek VA health care services and, thus, is a very important part of our planning efforts.

Enrollment in the VA health care system provides veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period. In addition to the assurance that services will be available, enrolled veterans will appreciate not having to repeat the application process—regardless of where they seek their care or how often.

Veterans Choose the VA Facility

As part of the enrollment process, a veteran may select any VA health care facility to serve as his/her primary treatment facility.

Benefits on the Go

VA enrollment also allows health care benefits to become completely portable throughout the entire VA system. Enrolled veterans who are traveling or who spend time away from their primary treatment facility may obtain care at any VA health care facility across the country without the worry of having to reapply.

Frequently Asked Questions (FAQs)

Do I have to enroll to receive VA health care?

While most veterans must be enrolled to receive VA health care, some veterans are exempt from the enrollment requirement due to meeting special eligibility criteria. If you fall into one of the following categories, you are not required to enroll.

- if you are seeking care for a VA-rated service-connected disability
- if VA has rated you with a service-connected disability of 50% or more
- if less than one year has passed since you were discharged for a disability that the military determined was incurred or aggravated in the line of duty, but that VA has not yet rated

Why does VA encourage enrollment from those veterans who Congress specifically exempted from the process?

The reason we encourage all potential VA health care patients to enroll is for planning and budgeting purposes. Enrollment numbers help to identify the potential demand for VA services. By including all potential patients in the enrollment count, including those that are exempt, we are in a much better position to identify necessary funding levels to Congress.

What if the demand for VA services exceeds its budget?

When the demand for services exceeds our ability to provide quality and timely health care, decisions will be made to ensure that the level of services for enrolled veterans is not compromised. Those decisions may include suspending enrollment of veterans in lower priority groups (such as VA's decision to restrict higher income veterans who fall into Priority Group 8 if they apply for care after January 16, 2003) or, in more drastic times, may include removing (disenrolling) lower priority group veterans from our enrollment system.

I already receive VA care, but I don't remember enrolling. How can I verify my enrollment?

If you are uncertain of your enrollment status, check with the Enrollment Coordinator at your local VA health care facility or you may call the VA Health Benefits Service Center at 1-877-222-VETS (8387).

VA HEALTH CARE ENROLLMENT

Veterans can apply for enrollment in the VA health care system by completing VA Form 10-10EZ, APPLICATION FOR HEALTH BENEFITS. The application form can be obtained by visiting, calling, or writing any VA health care facility or veterans' benefits office. Forms can also be requested toll-free from VA's Health Benefits Service Center at 1-877-222-VETS (8387) or accessed from our web site at www.va.gov/1010ez.htm. Completed applications must be signed and dated and may be returned in person or by mail to any VA health care facility. If you apply in person at a VA health care facility, VA staff will assign you to an initial priority group. After your application is processed, the VA Health Eligibility Center in Atlanta will confirm your enrollment status and priority group and will notify you of your enrollment status.

Financial Assessment (Means Testing)

While many veterans qualify for enrollment and cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans will be asked to complete a financial assessment as part of their enrollment application process. Otherwise known as the Means Test, this financial information will be used to determine the applicant's enrollment priority group (see Enrollment Priority Groups on page 7) and whether he/she is eligible for cost-free VA health care. Higher-income veterans may be required to share in the expense of their care by making copayments (see Copayment Requirements on pages 10 and 11). Veterans who choose not to complete the financial assessment must agree to pay the required copayments as a condition of their eligibility. Due to VA's restricting enrollment of new Priority Group 8 veterans who apply on or after January 17, 2003, veterans who decline to provide financial information and who agree to copayments will not be accepted for enrollment.

Veterans who are required to provide their financial information generally must do so on an annual basis. To simplify this annual reporting requirement, VA recently introduced a new, shorter version of its application form to be used for this annual reporting requirement. The new form, VA Form 10-10EZR, is to be used by enrolled veterans to update their previously reported information such as Address, Insurance, Employment and Financial information. It will save veterans time by eliminating the collection of information previously collected. The form can also be requested toll-free from VA's Health Benefits Service Center at 1-877-222-VETS (8387) or accessed from our web site at www.va.gov/1010ez.htm.

Geographically-Based Means Testing

Recognizing that the cost of living can vary significantly from one geographic area to another, Congress added income thresholds based upon geographic locations to the existing VA national income thresholds for financial assessment purposes. This change assists lower-income veterans who live in high-cost areas by providing an enhanced enrollment priority and reducing the amount of their required inpatient copayment.

Please note that the geographically-based copayment reductions apply ONLY to INPATIENT SERVICES- outpatient services, long-term care, as well as medication copayments are NOT affected by this change.

Health Insurance Coverage?

Since VA health care depends primarily on annual congressional appropriations, VA encourages veterans to retain any health care coverage they may already have—especially those in the lower enrollment priority groups as further described on pages 7 & 8, Enrollment Priority Groups. Veterans with private health insurance or with federally funded coverage through the Department of Defense (TRICARE), Medicare, or Medicaid, may choose to use these sources of coverage as a supplement to their VA benefits.

CAUTION! Before canceling insurance coverage, enrolled veterans should carefully consider the risks.

- There is no guarantee that in subsequent years Congress will appropriate sufficient funds for VA to provide care for all enrollment priority groups.
- Non-veteran spouses and other family members generally do not qualify for VA health care.
- If participation in Medicare Part B is cancelled, it cannot be reinstated until January of the next year and there may be a penalty for the reinstatement.

Reporting Health Insurance Information

By law, VA is obligated to bill health insurance carriers for services provided to treat nonservice-connected conditions. To ensure that current insurance information is on file—including coverage through employment or the veteran's spouse—VA staff is required to ensure that veterans' health insurance information is updated during each visit. Identification of insurance information is essential to VA since collections received from insurance companies help supplement the funding available to provide services to veterans. Veterans are asked to cooperate by disclosing all relevant health insurance information.

Insurance Collections

Since the start of insurance collections in 1986, veterans' health care services have been supplemented by over $9.3 billion allowing us to provide services to numerous additional veterans.

Must I reapply in subsequent years and will I receive an enrollment confirmation?

If you have previously enrolled, your enrollment will be reviewed annually without any action necessary on your part. Veterans who are required to update their financial information are still required to provide their income information on an annual basis using the form VA 10-10EZR. Depending on your priority group and the availability of funds for VA to provide medical benefits to all enrollees, your enrollment will be automatically renewed without any action on your part. Should there be any change to your enrollment status, you will be notified in writing.

If enrolled, must I use the VA as my exclusive health care provider?

While there is no requirement that VA become your exclusive provider of care, please be aware that our authority to pay for non-VA care is extremely limited (see page 15). You may, however, elect to use your private health insurance benefits as a supplement for your VA health care benefits.

What income is counted for the Means Test and is family size considered?

VA considers your previous year's total household income (both earned and unearned income) for you as well as your spouse and dependent children. Earned income is usually wages you receive from working. Unearned income can be interest earned, dividends received, money from retirement funds, Social Security payments, annuities or earnings from other assets. The number of persons in your family will be factored into the calculation to determine the applicable income threshold—both the VA national income threshold and the income threshold for your geographic region.

What is a Geographic Threshold?

By regulation, VA is required to identify veterans who agree to make VA medical care copayments and whose family incomes are below the "low-income" limits for the geographical area set annually by the U.S. Department of Housing and Urban Development (HUD) for public housing benefits. Those veterans whose incomes and assets fall between the VA means test limits and the HUD low-income limits will have their inpatient medical care copayments reduced by 80% starting October 1, 2002. The remaining higher income veterans will continue to pay the full inpatient medical care copayments and will be assigned the means test status "MT Copayment Required". This regulation has no affect on outpatient and medication copayments.

For those veterans who have more than one residence, which address is used for means testing under the geographically-based income thresholds?

The address used to determine your geographically-based income threshold is your permanent address. Typically, it is the location in which you declare residency for voting and tax purposes.

How frequently are the thresholds updated?

Income thresholds, used for the national Means Test as well as for geographic adjustments for high cost-of-living areas, are updated annually.

VA HEALTH CARE ENROLLMENT PRIORITY GROUPS

Upon receipt of a completed application (must include signature and date), the veteran's eligibility will be verified. Based on his/her specific eligibility status, he/she will be assigned to one of the following priority groups. The groups range from 1 through 8 with Priority Group 1 being the highest priority and Priority Group 8 the lowest.

Priority Group 1

- Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2

- Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- Compensable 0% service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans seeking care solely for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War; or
  - for any illness associated with service in a theater of combat operations during a period of war after the Gulf War or during a period of hostility after November 11, 1998; or
  - for illness possibly related to participation in Project 112/Project SHAD.

Priority Group 7

Veterans who agree to pay specified copayments with income and/or net worth ABOVE the VA Means Test threshold and income BELOW the geographically based threshold for their locality

- Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans not included Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified copayments with income and/or net worth ABOVE the VA Means Test threshold and income ABOVE the geographically-based threshold for their locality

- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

How has the application of the geographically-based income thresholds changed the financial assessment process and the enrollment priority groups?

While the financial assessment procedures have not been changed, application of the geographically based income thresholds has resulted in a division of the original Priority Group 7 into two separate priority groups. Priority Group 7 is now limited to nonservice-connected veterans and 0% noncompensable service-connected veterans whose combined income and net worth exceed VA's annually established national means test threshold BUT whose income is below the geographically-adjusted threshold established by HUD. Priority Group 8 includes all other nonservice-connected veterans and 0% noncompensable service-connected veterans whose income and net worth exceed VA's national means threshold AND whose income exceeds the threshold for their geographic location. In addition, Priority Group 8 also includes veterans who have declined to provide financial information and who, as a condition of their eligibility, have agreed to make required copayments if they applied before January 16, 2003.

What is a VA service-connected rating and how do I establish one?

A service-connected rating is an official ruling by VA that your illness/condition is directly related to your active military service. Service-connected ratings are established by VA Regional Offices located throughout the country. In addition to compensation and pension ratings, VA Regional Offices are also responsible for administering educational benefits, vocational rehabilitation, and other benefit programs including home loans. To obtain more information or to apply for any of these benefits, contact your nearest VA Regional Office at 1-800-827-1000 or visit us online at www.va.gov.

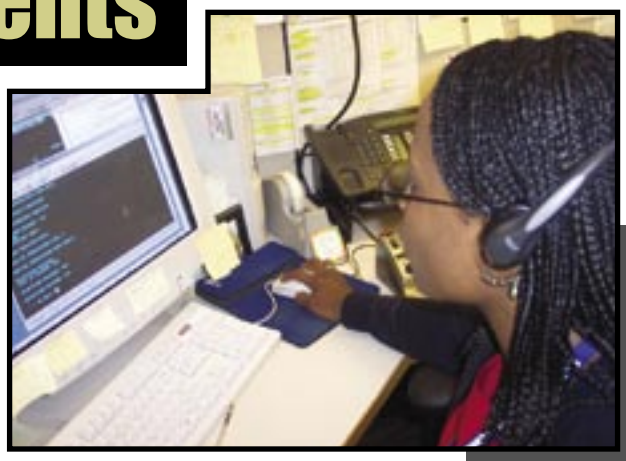
Who does the VA consider to be "catastrophically" disabled?

To be considered catastrophically disabled, you must have a severely disabling injury, disorder, or disease which permanently compromises your ability to carry out the activities of daily living. The disability must be of such a degree that you require personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to yourself or others. To request an evaluation, contact the Enrollment Coordinator at your local VA health care facility. If it is determined by a VA health care provider that you are catastrophically disabled, your priority will be upgraded to Priority Group 4. If, however, you were previously required to make copayments, that requirement will continue until your financial situation qualifies you for cost-free services.

Priority Groups 7 and 8 both have subpriority groups—a, c, e, and g. Are there subpriority groups b, d, and f?

Although the subpriority group designations (a, c, e, and g) are in descending order based on highest priority to lowest, they deliberately were not put in consecutive order. Since these designations are used exclusively for internal tracking purposes, we reserved b, d, and f for future use in the event of additional changes to the priority groups.

Copayment Requirements



While many veterans qualify for cost-free health care services based on a compensable service-connected condition or other qualifying factor, most veterans are required to complete an annual financial assessment or Means Test to determine if they qualify for cost-free services. Veterans whose income and net worth exceed the established Means Test threshold as well as those who choose not to complete the financial assessment must agree to pay required copayments to become eligible for VA health care services. Note that new veterans who apply for enrollment after January 16, 2003 and who decline to provide income information are not eligible for enrollment. Along with their enrollment confirmation and priority group assignment, enrollees will receive information regarding their copayment requirements, if applicable.

Types of Copayments

Outpatient Copayments*—based on the highest of two levels of service on any individual day.

- Primary Care Services—services provided by a primary care clinician (lower level of service).
- Specialty Care Services—services provided by a clinical specialist such as surgeon, radiologist, audiologist, optometrist, cardiologist, and specialty tests such as magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, and nuclear medicine studies (highest level of service).

**There is no copayment requirement for preventive care services such as screenings, immunizations, and other services that do not require the immediate presence of a physician.*

Medication Copayments*—applicable to each prescription including each 30-day supply or less of maintenance medications.

**Includes an annual cap for some enrollment priority groups.*

Inpatient Copayments—in addition to a standard copayment charge for each 90 days of care within a 365-day period regardless of the level of service (such as intensive care, surgical care, or general medical care), a per diem charge will be assessed for each day of hospitalization.

Long-Term Care Copayments*—based on three levels of care (see Long-Term Care Benefits on page 18 for definitions).

- Nursing Home Care/Inpatient Respite Care/Geriatric Evaluation
- Adult Day Health Care/Outpatient Geriatric Evaluation/Outpatient Respite Care
- Domiciliary Care

**Copayments for Long-Term Care services start on the 22nd day of care during any 12-month period—there is no copayment requirement for the first 21 days. Actual copayment charges will vary from veteran to veteran depending upon financial information submitted on VA Form 10-10EC.*

Annual Changes To Copayment Rates

Because of the annual changes to copayment rates—including the annual cap on medication copayments—they are published separately. Current year rates can be obtained at any VA health care facility or on the eligibility page on our web site www.va.gov/elig

Copayments

Who it applies to:

Priority Groups 7 & 8 with the exception of noncompensable 0% service-connected veterans whose treatment is for their service-connected condition.

Most veterans with the exception of the following.

- Veterans with a service-connected rating of 50% or greater
- Veterans requiring medications for the treatment of a service-connected condition
- Veterans requiring medications for the treatment of disorders related to ionizing radiation, service in a theater of combat operations or hostilities after 11/11/98, participation in Project 112/SHAD testing or Military Sexual Trauma.
- Veterans whose income does not exceed the maximum VA annual rate of pension
- Former Prisoners of War

I am a recently discharged combat veteran. Must I pay VA copayments?

If the services are provided for the treatment of a condition that may be related to your military service in a theater of combat operations, you will not be charged any copayments. This benefit is limited to a two-year period following military discharge. You will, however, be subject to means testing (and copayments, if applicable) for care of any condition clearly not related to your military service such as a broken limb or a problem that existed prior to entering service.

How many copayment charges may be assessed during a single day?

For outpatient services, you will be charged only one copayment, regardless of the number of health care providers you see in a single day. The amount of the outpatient copayment will be based on the highest level of service you received that day. For example, if you have a specialty care visit and a primary care visit on the same day, you will be charged only for the specialty care visit since it is a higher level of care. The number of medication copayments charged as a result of your outpatient visit depends on the number of each 30-day supply of medication filled. Inpatient copayments are based on both a standard charge for each 90 days of care within a 365-day period as well as a per diem (daily) charge. Together, the inpatient copay charges cover all services including medications. With the exception of medication copayments for outpatients, long-term care copayments are a single, all-inclusive charge.

Who qualifies for the annual cap on medication copayments?

The annual cap on medication copayments applies to Priority Groups 2 through 6 (Priority Group 1 is exempt from ALL copayments). Because of their higher financial status, veterans in Priority Groups 7 and 8 do NOT qualify for the medication copayment annual cap. For those that qualify, once the annual limit is reached, all subsequent prescriptions filled during the calendar year will be free of the copayment requirement.

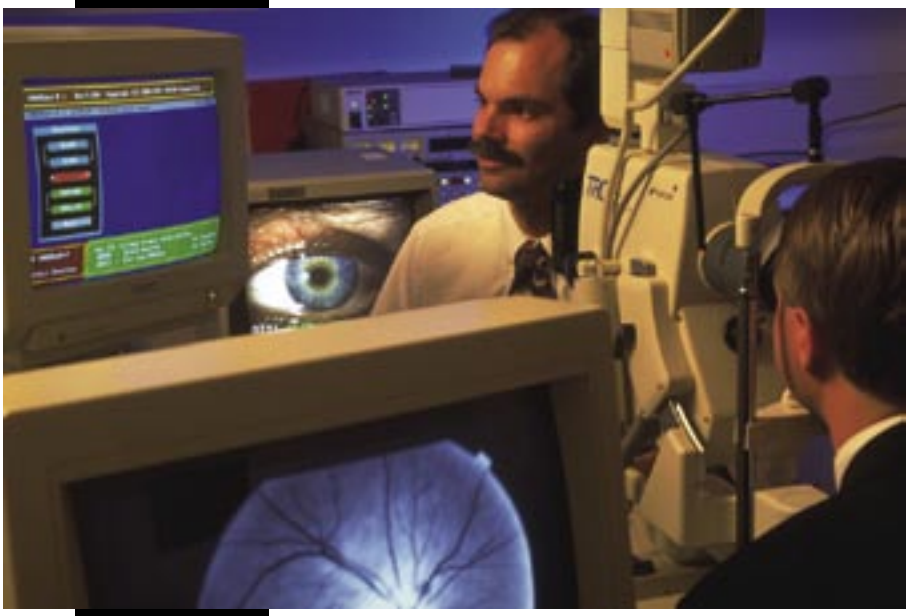
What if I am Unable to Pay the Copayments?

If there has been a significant decrease in your earned income from the previous year, your current projected income may be used on a case-by-case basis (VA calls this the Hardship Determination process. To apply for a Hardship Determination, consult your Enrollment Coordinator at your local VA medical facility.

I obtain medications from VA's mail-out pharmacy program. What is the copayment for a 90-day supply?

Even though the prescription is written for 90-days, each 30-day or less supply is subject to that year's applicable medication copayment rate. In your case, your 90-day supply would cost you 3 times the medication copayment rate.

VA HEALTH CARE COVERED SERVICES
ACUTE CARE BENEFITS



Standard Benefits

The following acute care services are available to all enrolled veterans.

Preventive Care Services

- Immunizations
- Physical Examinations (including eye and hearing examinations)
- Health Care Assessments
- Screening Tests
- Health Education Programs

Ambulatory (Outpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Hospital (Inpatient) Diagnostic and Treatment Services

- Medical
- Surgical (including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Substance Abuse

Prescription Drugs (when prescribed by a VA physician)

Limited Benefits

The following acute care services (partial listing) have limitations and may have special eligibility criteria:

- Ambulance Services
- Dental Care
- Durable Medical Equipment
- Eyeglasses
- Hearing Aids
- Home Health Care
- Homeless Programs
- Maternity and Parturition Services—usually provided in non-VA contracted hospitals at VA expense, care is limited to the mother (costs associated with the care of newborn are not covered)
- Non-VA Health Care Services
- Orthopedic, Prosthetic, and Rehabilitative Devices
- Rehabilitative Services
- Readjustment Counseling
- Sexual Trauma Counseling

General Exclusions (partial listing)

- Abortions and abortion counseling
- Cosmetic surgery except where determined by VA to be medically necessary for reconstructive or psychiatric care
- Gender alteration
- Health club or spa membership, even for rehabilitation
- In-vitro fertilization
- Drugs, biological, and medical devices not approved by the Food and Drug Administration unless part of formal clinical trial under an approved research program or when prescribed under a compassionate use exemption.
- Medical 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 provide the care or services.
- Services not ordered and provided by licensed/accredited professional staff
- Special private duty nursing

Hearing aids and eyeglasses are listed as "limited" benefits. Under what circumstances do I qualify?

To qualify for hearing aids and eyeglasses you must have a VA service-connected disability rating of 10% or more. You may also qualify if you are a former prisoner of war, Purple Heart recipient, require this benefit for treatment of a 0% service-connected condition or are receiving increased pension based on your need for regular aid and attendance or being permanently housebound.

Am I eligible for dental care?

You are eligible for dental services if your dental care is for either a compensable service-connected condition, a dental condition resulting from service-connected trauma, or if you have a service-connected rating of 100 percent. You also qualify if you are a former prisoner of war, a participant in a VA vocational rehabilitation program, or if your dental condition is aggravating a medical problem under VA treatment. In addition, you may also qualify for one-time dental treatment if you have been recently discharged from military service, had a documented dental condition while in service, and your discharge certificate does not include certification that all appropriate treatment had been rendered prior to being released.

Am I limited to a specific number of inpatient days or outpatient visits during a given period of time?

For acute care services (inpatient days of care and outpatient visits) there are no limits.

Do I qualify for routine health care at non-VA facilities at VA expense?

To qualify for routine care at non-VA facilities at VA expense (otherwise known as fee-basis care), you must first be given specific authorization by your VA provider. Included among the factors in determining whether such care will be authorized is your medical condition and availability of VA services within your geographic area.

Am I eligible for emergency care at non-VA facilities?

You are eligible if the non-VA emergency care is for a service-connected condition or, if enrolled, you have been provided care by a VA clinician or provider within the past 24 months and have no other health care coverage or ability to pay for the services. Also, it must be determined that VA health care facilities were not feasibly available; that a delay in medical attention would have endangered your life or health, and that you are personally liable for the cost of the services.

Is VA approval needed before I obtain non-VA emergency services?

While approval is not required, notification to the nearest VA health care facility must be made within 48 hours if hospitalization is required. Since VA payment is limited up to the point your condition is stable for transportation to a VA facility, transfer arrangements should be made as soon as possible.

Does the VA offer compensation for travel expenses to and from a VA facility?

If you meet specific criteria (see next question), you are eligible for travel benefits. In most cases, travel benefits are subject to a deductible. Exceptions to the deductible requirement are: 1) travel for a compensation and pension examination; and 2) travel by an ambulance or a specially equipped van. Because travel benefits are subject to annual mileage rate and deductible changes, we publish a separate document each year. You can obtain a copy at any VA health care facility.

Do I qualify for travel benefits?

You may qualify for beneficiary travel payments if you fall into one of the following categories.

- you have a service-connected rating of 30 percent or more
- you are traveling for treatment of a service-connected condition
- you receive a VA pension
- you are traveling for a scheduled compensation or pension examination
- your income does not exceed the maximum annual VA pension rate
- your medical condition requires an ambulance or a specially equipped van, you are unable to defray the cost, and the travel is pre-authorized (authorization is not required for emergencies if a delay would endanger your life or health)

Long-Term Care Benefits

Standard Benefits

The following long-term care services are available to all enrolled veterans.

Geriatric Evaluation

Geriatric evaluation is the comprehensive assessment of a veteran's ability to care for him/herself, his/her physical health, and social environment, which leads to a plan of care. The plan could include treatment, rehabilitation, health promotion, and social services. These evaluations are performed by inpatient Geriatric Evaluation and Management (GEM) Units, GEM clinics, geriatric primary care clinics, and other outpatient settings.

Adult Day Health Care

The adult day health care (ADHC) program is a therapeutic day care program, providing medical and rehabilitation services to disabled veterans in a combined setting.

Respite Care

Respite care provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief from the physical and emotional demands associated with providing care. Respite care can be provided in the home or other noninstitutional settings.

Home Care

Skilled home care is provided by VA and contract agencies to veterans that are homebound with chronic diseases and includes nursing, physical/occupational therapy, and social services.

Hospice/Palliative Care

Hospice/palliative care programs offer pain management, symptom control, and other medical services to terminally ill veterans or veterans in the late stages of the chronic disease process. Services also include respite care as well as bereavement counseling to family members.

Financial Assessment for Long-Term Care Services

For veterans who are not automatically exempt from making copayments for long-term care services (see Copayment Requirements on page 10), a separate financial assessment (VA Form 10-10EC, APPLICATION FOR EXTENDED CARE SERVICES) must be completed to determine whether they qualify for cost-free services or to what extent they are required to make long term care copayments. For those veterans who do not qualify for cost-free services, the financial assessment for long term care services is used to determine the copayment requirement. Unlike copayments for other VA health care services, which are based on fixed changes for all, long-term care copayment charges are individually adjusted based on each veteran's financial status.

Limited Benefits

Nursing Home Care

While some veterans qualify for indefinite nursing home care services, other veterans may qualify for a limited period of time. Among those that automatically qualify for indefinite nursing home care are veterans whose service-connected condition is clinically determined to require nursing home care and veterans with a service-connected rating of 70% or more. Other veterans—with priority given to those with service-connected conditions—may be provided short-term nursing home care if space and resources are available.

Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health maintenance care for veterans who require some medical care, but who do not require all the services provided in nursing homes. Domiciliary care emphasizes rehabilitation and return to the community. VA may provide domiciliary care to veterans whose annual income does not exceed the maximum annual rate of VA pension or to veterans who have no adequate means of support.

I already provided financial information on my initial VA application, why is it necessary to complete a separate financial assessment for long-term care?

Unlike the information collected from the Means Test, which is based on your previous year's income, the 10-10EC is designed to assess your current financial status, including current expenses. This in-depth analysis provides the necessary monthly income/expense information to determine whether you qualify for cost-free long-term care or a significant reduction from the maximum copayment charge.

Once I submit a completed VA Form 10-10EC, who notifies me of my long-term care copayment requirements?

The social worker or case manager involved in your long-term care placement will provide you with an annual projection of your monthly copayment charges.

Assuming I qualify for nursing home care, how is it determined whether the care will be provided in a VA facility or a private nursing home at VA expense?

Generally, if you qualify for indefinite nursing home care, that care will be furnished in a VA facility. Care may be provided in a private facility under VA contract when there is compelling medical or social need. If you do not qualify for indefinite care, you may be placed in a community nursing home—generally not to exceed six months—following an episode of VA care. The purpose of this short-term placement is to provide assistance to you and your families while alternative, long-term arrangements are explored.

For veterans who do not qualify for indefinite nursing home care at VA expense, what assistance is available for making alternative arrangements?

When the need for nursing home care extends beyond the veteran's eligibility, our social workers will help family members identify possible sources for financial assistance. Our staff will review basic Medicare and Medicaid eligibility and direct the family to the appropriate sources for further assistance, including possible application for additional VA benefit programs.

Additional VA health care

Veterans

In addition to the VA health care system, which administers benefits to veterans residing within the United States, VA also provides benefits to service-connected veterans outside the country.

VA Foreign Medical Program —a health care benefits program for US veterans with VA-rated service-connected conditions who are living or traveling abroad. Foreign benefits are administered by three separate offices (as indicated below) depending on where the health care services are obtained.

in Canada

address
VAM&RO Center (136FC)
North Hartland Road
White River Junction VT 05009-0001

e-mail
vavbawrj/ro/vse@vba.va.gov

fax
303.331.7803

Veterans in the Philippines

address
VA Outpatient Clinic (358/00)
2201 Roxas Blvd.
Pasay City 1300
Republic of the Philippines

e-mail
manlopc.inqry@vba.va.gov

fax
011-632-838-4566

all other countries

address
Foreign Medical Program
PO Box 65021
Denver CO 80206-9021

telephone
303.331.7590

e-mail
hac.fmp@med.va.gov

fax
303.331.7803

web site
www.va.gov/hac

Dependents & Survivors

CHAMPVA—a health care benefits program for:

- dependents of veterans who have been rated by VA as having a total and permanent disability;
- survivors of veterans who died from VA-rated service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a VA-rated service-connected condition; and
- survivors of persons who died in the line of duty and not due to misconduct and not otherwise entitled to benefits under DoD's TRICARE program.

address
CHAMPVA
PO Box 65023
Denver CO 80206-9023

Telephone
800.733.8387

e-mail
hac.inq@med.va.gov

fax
303.331.7804

web site
www.va.gov/hac

Children of Women Vietnam Veterans Health Care Benefits—a program designed for women Vietnam veterans' birth children who are determined by a VA Regional Office to have one or more covered birth defects.

address
Children of Women Vietnam Veterans
PO Box 469027
Denver CO 80246-9027

telephone
888.820.1756

email
cwvv.inq@med.va.gov

fax
303.331.7807

web site
www.va.gov/hac

Spina Bifida Health Care Benefits—a program designed for Vietnam veterans' birth children diagnosed with spina bifida and who are in receipt of a VA Regional Office award for spina bifida benefits.

address
Spina Bifida Health Care
PO Box 65025
Denver CO 80206-9025

e-mail
spina.inq@med.va.gov

telephone
888.820.1756

fax
303.331.7807

web site
www.va.gov/hac

For more information on
VA health care, call toll-free
1-877-222-VETS (8387)
or online at **www.va.gov/elig**

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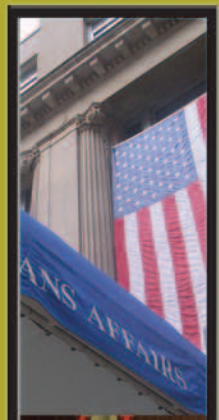

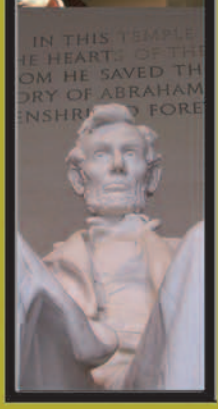

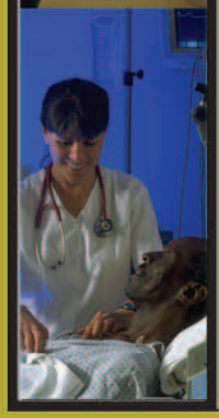

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