

Veterans Administration		APPLICATION FOR MEDICAL BENEFITS	
1. TYPE OF BENEFIT APPLIED FOR: <input type="checkbox"/> HOSPITAL TREATMENT <input type="checkbox"/> DOMICILIARY CARE <input type="checkbox"/> OUT-PATIENT MEDICAL <input type="checkbox"/> OUT-PATIENT DENTAL <input type="checkbox"/> NURSING HOME CARE		2. APPLICANT'S NAME (Last - first - middle initial)	3. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
6. SOCIAL SECURITY NO.		7. CLAIM NO.	8. DATE OF BIRTH
10. ARE YOU? <input type="checkbox"/> A. SERVICE CONNECTED <input type="checkbox"/> B. RECEIVING A VA PENSION <input type="checkbox"/> C. RECEIVING MILITARY RETIREMENT PAY <i>(If A, B, or C is checked, give disability, percent and/or amount received.)</i>		4. ADDRESS (Street, City, County & ZIP Code)	
11. RELIGION		5. TELEPHONE NO.	
12. MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. PLACE OF BIRTH	
13. PERSON TO BE NOTIFIED IN CASE OF AN EMERGENCY	NAME AND ADDRESS	TELEPHONE NO.	RELATIONSHIP
14. NAME, ADDRESS AND TELEPHONE NO. OF EMPLOYER		15. OCCUPATION	16. HEALTH INSURANCE COVERAGE (List policies and numbers.)
17. IS YOUR NEED FOR CARE: <input type="checkbox"/> NO <input type="checkbox"/> YES	A. RELATED TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES	B. DUE TO AN ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(If "Yes" attach an explanation, including the name and address of the person or organization involved.)</i>	
18. HAVE YOU PREVIOUSLY RECEIVED CARE FROM VA? <input type="checkbox"/> NO <input type="checkbox"/> YES	A. IF YES, WHAT KIND, WHERE AND WHEN		B. LOCATION OF CLAIMS FOLDER
19. I HEREBY AFFIRM THAT I AM <input type="checkbox"/> ABLE <input type="checkbox"/> UNABLE TO DEFRAY THE NECESSARY EXPENSES OF THE MEDICAL CARE FOR WHICH I AM APPLYING.			
20. ACTIVE MILITARY SERVICE AND RECORD OF ACTIVE DUTY STATUS			
<input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> COAST GUARD <input type="checkbox"/> OTHER (Specify)	SERVICE NUMBER	DATE ENTERED SERVICE	DATE SEPARATED
POW (If "Yes," check appropriate war) (If "Yes," check base) <input type="checkbox"/> NO			
<input type="checkbox"/> WWI <input type="checkbox"/> WWII (Europe) <input type="checkbox"/> WWII (South Pacific) <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAM	TYPE OF DISCHARGE		
21. DENTAL CONDITION (Fill this in if benefit applied for is related to a dental condition.)			
A. WAS IT CAUSED BY INJURY IN MILITARY SERVICE? <input type="checkbox"/> NO <input type="checkbox"/> YES		B. WERE ANY TEETH EXTRACTED IN MILITARY SERVICE? <input type="checkbox"/> NO <input type="checkbox"/> YES	
22. MEDICAL OR DENTAL TREATMENT RECEIVED DURING OR AFTER MILITARY SERVICE			
A. DATES	B. LIST CONDITIONS TREATED, PLACE OF TREATMENT AND FROM WHOM TREATMENT WAS RECEIVED (If necessary, continue on a sheet of plain paper)		C. APPROXIMATE DATE CONDITION WAS FIRST NOTED.
NOTE - The law (38 USC 5220 et seq.) provides that upon the death of any veteran requiring care or treatment by the Veterans Administration in any institution leaving no widow(widower), next of kin or heir entitled to inherit, all personal property, including money or balances in bank, and all claims and choses in action, owned by such veteran, and not disposed of by will or otherwise, will become the property of the United States as trustee for the Post Fund.			
23. I DESIGNATE THE FOLLOWING PERSON(S), IN THE ORDER LISTED, TO RECEIVE POSSESSION OF ALL PERSONAL PROPERTY LEFT ON THE PREMISES UNDER VA CONTROL AFTER I LEAVE SUCH PLACE OR AT THE TIME OF MY DEATH. (This does not constitute a will or transfer of title)			
NAME, ADDRESS AND ZIP CODE		TELEPHONE NO.	RELATIONSHIP
The information requested on this form is solicited under authority of Title 38, U.S.C., "Veterans' Benefits," and will be used to determine your eligibility for medical benefits, identify your medical records, and provide basic data for your treatment. Additional information, such as medical history, may be solicited during the course of your medical evaluation or treatment. The information you supply also may be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your request promptly and serve your medical needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.			
24. I UNDERSTAND THE QUESTIONS, AND ALL ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.		FOR VA USE ONLY	
SIGNATURE OF APPLICANT OR APPLICANT'S REPRESENTATIVE	DATE	ADMISSION DATE	AUTHORITY FOR ADMISSION OR TREATMENT
WARNING: If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to prosecution in a U.S. Court.			

## INSTRUCTIONS FOR COMPLETING APPLICATION FOR MEDICAL BENEFITS

This will help you complete an application for hospitalization, domiciliary care, outpatient treatment or nursing home care. Look under the heading that identifies the kind of benefit you are seeking. Select the category under that heading which applies to you. Then follow the instructions which are shown directly opposite that category in the column on the right.

REQUESTING TREATMENT IN A HOSPITAL OR VA NURSING HOME CARE UNIT	INSTRUCTIONS
You require treatment for a condition adjudicated <b>SERVICE-CONNECTED</b> by the Veterans Administration or for a condition which resulted in discharge for disability incurred in line of duty.	→ Complete VA Form 10-10, except for items 14, 16, 17, 19, 21 and 22. Have your physician complete VA Form 10-10m.
You require treatment for a condition <b>UNRELATED</b> to your service and you have a disability rated as service-connected by the Veterans Administration, or you were discharged for disability incurred in line of duty.	→ Complete VA Form 10-10 except for items 16, 19, 21 and 22. Have your physician complete VA Form 10-10m.
You require treatment for a <b>NON-SERVICE-CONNECTED</b> disability. You are receiving a pension from the Veterans Administration, or you <b>ARE 65 YEARS</b> of age or older, or are eligible for Medicaid coverage.	→ Complete VA Form 10-10, except for items 16, 19, 21, and 22. Have your physician complete VA Form 10-10m.
You require treatment for a <b>NON-SERVICE-CONNECTED</b> condition and you are <b>NOT 65 YEARS</b> of age or older and you are <b>NOT</b> receiving a pension from the Veterans Administration, or are <b>NOT</b> eligible for Medicaid coverage.	→ Complete VA Form 10-10 except for items 21 and 22. Please read additional instructions at bottom of page. Have your physician complete VA Form 10-10m.
<b>REQUESTING TREATMENT IN A COMMUNITY NURSING HOME AT VA EXPENSE</b>	
You require treatment for a condition adjudicated <b>SERVICE-CONNECTED</b> by the Veterans Administration.	→ Complete VA Form 10-10, except for items 14 through 17, 19, 21 and 22. Have your physician complete VA Form 10-10m.
<b>REQUESTING DOMICILIARY CARE</b>	
You have a disability, rated as service-connected by the Veterans Administration, or you are receiving a Veterans Administration <b>PENSION</b> , or you were discharged for disability incurred in line of duty, or are eligible for Medicaid coverage, or are 65 years of age or older.	→ Complete VA Form 10-10, except for items 14 through 17, 19, 21 and 22. Have your physician complete VA Form 10-10m.
You are not in any category in the above paragraph.	→ Complete VA Form 10-10, except for items 17, 21 and 22. Please read additional instructions at bottom of page. Have your physician complete VA Form 10-10m.
<b>REQUESTING OUTPATIENT TREATMENT</b>	
You are requesting outpatient medical or dental treatment.	→ Complete VA Form 10-10, except for items 11, 12 and 23. Do not complete item 19 if you have a disability rated as service-connected by the VA, or are in receipt of VA pension or military disability retirement pay.

### ADDITIONAL INSTRUCTIONS

If you are an applicant who is required to complete Item 19 of VA Form 10-10, please read the following remarks before completing Item 19 (Ability or Inability to Defray Costs of Medical Care):

Applicants for treatment of nonservice-connected conditions who do not have a service-connected disability; or are under age 65; or are not in receipt of VA pension benefits; or are not eligible to receive medical assistance under Medicaid are required by law (Title 38, United States Code) to certify their inability to pay for other than VA hospitalization, nursing home or domiciliary care. This certification is subject to review on a case by case basis by the VA. The VA will make the final determination of whether to provide the needed care based on the following factors:

1. The applicant's monthly income from all sources. (*Including that of the spouse*)
2. The cash value of the applicant's ready assets, other than home of residence (Cash, savings deposits, stocks, bonds, property, etc.)
3. The applicant's entitlement to medical care under an insurance policy of any kind, including insurance liability of third parties in accident cases and CHAMPUS or Medicare coverage.

IF YOU HAVE ANY QUESTIONS WITH RESPECT TO THIS MATTER, VA RECEPTION PERSONNEL WILL BE GLAD TO ASSIST YOU.

IF THIS IS YOUR FIRST APPLICATION FOR VA CARE, WE CAN PROCESS IT MORE QUICKLY IF YOU ATTACH A COPY OF YOUR DD 214, OR OTHER PROOF OF MILITARY SERVICE.