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Expiration Date: 4/30/2007

APPLICATION FOR FURNISHING NURSING HOME CARE TO BENEFICIARIES OF VETERANS AFFAIRS

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 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. This information is used to determine your qualifications to provide Nursing Home Care. Although this information is voluntary, failure to provide it will delay or prevent our approval of your facility.

1A. NAME/ADDRESS OF NURSING HOME (Number, Street, City, County, State, ZIP)	1B. TELEPHONE	3. IF THIS NURSING HOME IS PART OF A CHAIN, SPECIFY
	2. PROVIDER NUMBER	

4. IS NURSING HOME LICENSED OR APPROVED BY STATE IN WHICH LOCATED (Check one)	5. IS NURSING HOME ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS (If "YES", give date)	6. NURSING HOME IS CERTIFIED FOR PARTICIPATION IN	7. NURSING HOME IS LICENSED AS (Check where applicable)
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **MEDICARE PROGRAM** ☐ **MEDICAID PROGRAM**	☐ SKILLED NURSING FACILITY ☐ INTERMEDIATE CARE FACILITY ☐ OTHER (Specify)

8. LICENSED BED CAPACITY (Specify Number)	SNF BEDS	ICF BEDS	9. NUMBER OF BEDS OCCUPIED ON FILING DATE
	COMBINED SNF/ICF OF BEDS	TOTAL BEDS	

10. TYPE OF PATIENTS ACCEPTED (Check all applicable)				
	☐ A. MALE	☐ E. WHEELCHAIR	☐ I. PSYCHIATRIC	☐ M. ASSISTANCE IN FEEDING
	☐ B. FEMALE	☐ F. NON-AMBULATORY	☐ J. TERMINAL	☐ N. OTHER (Specify)
	☐ C. DIABETIC	☐ G. PARAPLEGIC	☐ K. CONFUSED	
	☐ D. BLIND	☐ H. NEUROLOGICAL	☐ L. CHRONIC INCONTINENCE	

11. MEDICAL CARE	A. ARE ALL THE PATIENTS UNDER THE CARE OF A PHYSICIAN	B. IS A WRITTEN HISTORY AND PHYSICAL EXAMINATION DONE ON ADMISSION	C. NAME AND ADDRESS OF PHYSICIAN WHO ADVISES HOME ON PROFESSIONAL MATTERS
	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	

12. NURSING CARE		
	A. NAME OF DIRECTOR OF NURSING SERVICE	B. IS DIRECTOR CURRENTLY LICENSED IN STATE WHERE NURSING HOME IS LOCATED ☐ **YES** ☐ **NO**
	C. REGISTRATION NUMBER	D. IS THERE AN IN-SERVICE TRAINING PROGRAM FOR ALL NURSING PERSONNEL ☐ **YES** ☐ **NO**

13. PHYSICAL FACILITIES				
	A. DATE FACILITY BUILT	B. DATES EXPANDED OR MAJOR REMODELING (mm/dd/yyyy)		C. NUMBER OF BEDS AFFECTED
	D. CONSTRUCTION OF OUTSIDE WALLS	E. CONSTRUCTION OF ROOF	F. IS THERE A BASEMENT ☐ **YES** ☐ **NO**	G. ARE EXTERIOR WALLS AT LEAST ONE HOUR FIRE RESISTANT ☐ **YES** ☐ **NO**
	H. IS THERE AN AUTOMATIC FIRE SPRINKLER SYSTEM THROUGHOUT THE FACILITY ☐ **YES** ☐ **NO**	I. IS NURSING HOME ACCESSIBLE TO HANDICAPPED ☐ **FULLY** ☐ **PARTIALLY** ☐ **NOT AT ALL**		J. DOES NURSING HOME MEET NFPA 101 SAFETY STANDARDS (If "Yes", which edition.) ☐ **YES** ☐ **NO**

	14. STAFFING (Enter number in normal tour of duty for each day)	FULL-TIME (40 hours per week)	PART-TIME (Specify hours per week)
A. ADMINIS-TRATION	ADMINISTRATOR (If also serves as nurse, do not count but include in 14B)		
	ASSISTANT ADMINISTRATOR		
	ACCOUNTANT		
	OTHER (Specify)		
B. NURSING	REGISTERED NURSES		
	LICENSED VOCATIONAL/PRACTICAL NURSES		
	NURSING ASSISTANTS/AIDES		

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	14. STAFFING (Enter number in normal tour of duty for each day)	FULL-TIME (40 hours per week)	PART-TIME (Specify hours per week)
C. DIETARY STAFF	DIETITIAN-AMERICAN DIETETIC ASSOCIATION		
	COOK		
	ALL OTHER KITCHEN HELP		
D. DIRECT CARE STAFF (Exclusive of Nursing)	PHYSICAL/CORRECTIVE THERAPIST		
	OCCUPATIONAL/MANUAL ARTS THERAPIST		
	SOCIAL WORKER		
	RECREATIONAL/ACTIVITIES DIRECTOR		
	BEAUTICIANS/BARBERS		
	PHARMACIST		
	VOLUNTEERS *(Including clergy)*		
E. OTHER	HOUSEKEEPING STAFF		
	JANITORS/MAINTENANCE STAFF		
	LAUNDRY		
	ENGINEERING		
	OTHER (Specify)		

15. REMARKS

I HEREBY CERTIFY THAT INFORMATION ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

16A. TYPED NAME OF ADMINISTRATOR	16B. SIGNATURE OF ADMINISTRATOR	16C. DATE