

**Please Read Before You Start . . .****What is VA Form 10-10CG used for?**

To apply for VA's Program of Comprehensive Assistance for Family Caregivers. VA will use the information on this form to assist in determining your eligibility; a clinical assessment will also be required. An eligible Veteran may appoint one (1) Primary Family Caregiver and up to two (2) Secondary Family Caregivers. On average, it will take 15 minutes to complete the application including the time it will take you to read instructions, gather the necessary facts and fill out the form. Each time a new Caregiver is appointed a new Form 10-10CG is required.

**Where can I get help filling out the form and answers to questions?**

You may use ANY of the following to request assistance: Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387). Access VA's website at <http://www.va.gov> and select "Contact the VA". Locate and contact the Caregiver Support Coordinator at your nearest VA health care facility. A Caregiver Support Coordinator locator is available at <http://www.caregiver.va.gov/>. Contact the National Caregiver Support Line by calling 1-855-260-3274 or a Veterans Service Organization.

**Definitions of terms used in this form****Caregiver Support Coordinator (CSC):**

A VA clinical professional who connects Caregivers of Veterans with VA and community resources offering supportive programs and services. Caregiver Support Coordinators are located at every VA medical center and are designated specialists in Caregiving issues.

**Family Member:**

A member of the Veteran's or Servicemember's family (including a parent, a spouse, a son or daughter, a step-family member, and an extended family member), or an individual who lives full-time with the Veteran or Servicemember, or will do so if approved as a Primary or Secondary Family Caregiver.

**Injured in the Line of Duty (LOD):**

An injury incurred or aggravated during active military service, unless the injury resulted from the Veteran's or Servicemember's willful misconduct or abuse of alcohol or drugs, or it occurred while that individual was avoiding duty by desertion, or absent without leave which materially interfered with the performance of military duty.

**Power of Attorney (POA):**

A Power of Attorney is an authorization for someone to act on the Veteran's or Servicemember's behalf when completing this form.

**Primary Family Caregiver:**

A Family Member (defined herein), who is designated as a "primary provider of personal care services" under 38 U.S.C. §1720G(a)(7)(A); and who meets the requirements of 38 C.F.R. §71.25.

**Representative:**

Refers to a Veteran's or Servicemember's court-appointed legal guardian or special guardian, Durable POA for Health Care, or other designated health care agent. Copies of documentation regarding representatives are requested on this application.

**Secondary Family Caregiver:**

An individual approved as a "provider of personal care services" for the eligible Veteran under 38 U.S.C. §1720G(a)(7)(A); meets the requirements of 38 C.F.R. §71.25; and generally serves as a back-up to the Primary Family Caregiver.

**Stipend:**

An allowance given to a Primary Family Caregiver in acknowledgement of the sacrifices they are making to care for a seriously injured eligible Veteran (as defined in 38 C.F.R. §71.15).

**Who should apply for VA's Program of Comprehensive Assistance for Family Caregivers?**

IF THE INDIVIDUAL IS A:	AND	AND	THEN
<b>Veteran or Servicemember</b> who has been issued a date of medical discharge from the military	Requires on-going supervision or assistance with performing basic functions of everyday life due to a serious injury or mental disorder (including traumatic brain injury, psychological trauma or other mental disorder) incurred or aggravated in <b>the line of duty on or after September 11, 2001</b>	Requires at least 6 months of continuous Caregiver support	The Veteran or Servicemember may meet the criteria for VA's Program of Comprehensive Assistance for Family Caregivers. Complete this form to apply

Veterans and Servicemembers who do not meet the criteria for VA's Program of Comprehensive Assistance for Family Caregivers may be eligible for VA health benefits and other caregiver support services. To find out about other caregiver support services, contact the Caregiver Support Coordinator (CSC) at your local VA health care facility. To obtain the name of your local CSC, contact the Caregiver Support Line at 1-855-260-3274 or go to [www.caregiver.va.gov](http://www.caregiver.va.gov) and use the Find Your Local Caregiver Support Coordinator option.

**Getting Started:**

Answer all questions on the form. If you are not enrolled in VA's health care system or are currently Active Duty undergoing medical discharge, submit VA Form 10-10EZ "Application for Health Benefits" with this form. Enrolled Veterans may submit VA Form 10-10EZ "Health Benefits Renewal Form" with their completed VA Form 10-10CG to provide information updates. Do NOT exceed the designated spaces (e.g., do NOT extend Last Name into First Name area). The Veteran's or Servicemember's representative or POA may complete this application; however the POA/Representation documents must be provided with this application.

**SECTION I --VETERAN AND SERVICEMEMBER GENERAL INFORMATION**

Directions for Section I --Veteran/Servicemember, representative or POA, please answer all questions, **sign and date**.

**SECTION II --PRIMARY FAMILY CAREGIVER GENERAL INFORMATION**

Directions for Section II --Primary Family Caregiver applicant, please answer all questions, including health insurance information, **sign and date**.

**SECTION III --SECONDARY FAMILY CAREGIVER(S) GENERAL INFORMATION**

Directions for Section III --Secondary Family Caregiver applicant(s) please answer all questions, **sign, and date**. A Veteran/ Servicemember may appoint up to two Secondary Family Caregivers but this is not required. If a Veteran/Servicemember elects to appoint a Secondary Family Caregiver at a later time, Sections I and III in a new 10-10CG must be completed.

**Submitting your application.**

1. Read Paperwork Reduction and Privacy Act Information.
2. The Veteran or an individual delegated as the Veteran's representative/POA must sign and date the form.
3. Attach POA/Representation documents to the application, if applicable.
4. For expedited processing, mail this application to:

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

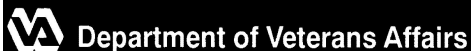
If you prefer to present or take this application in person, you may hand carry the printed and signed application to your local VA Medical Center Caregiver Support Coordinator (CSC). To obtain the name of your local CSC, contact the Caregiver Support Line at 1-855-260-3274 or go to <http://www.caregiver.va.gov> and use the **Find Your Local Caregiver Support Coordinator option**.

**THE PAPERWORK REDUCTION ACT**

This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time to read instructions, gather necessary data, and fill out the form. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Completion of this form is mandatory for eligible Veterans who wish to participate in the Caregiver Program.

**PRIVACY ACT INFORMATION**

**Privacy Act Information: Privacy Act Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 101, 5303A, 1705, 1710, 1720B, and 1720G, in order for VA to determine your eligibility for medical benefits. 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records, "Patient Medical Records --VA" (24VA19), "Enrollment and Eligibility Records --VA" (147VA16), and "Health Administration Center Civilian Health and Medical program Records--VA" (54VA17) and in accordance with the VHA Notice of Privacy Practices. Providing the requested information, including Social Security Number, is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect 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.



## Application for Comprehensive Assistance for Family Caregivers Program

**Attention:** Complete the application (print or typewritten only) and mail it to: Program of Comprehensive Assistance for Family Caregivers, Health Eligibility Center, 2957 Clairmont Road NE, Ste 200, Atlanta, GA 30329-1647, for expedited processing; or, hand carry it to your local VA Medical Center Caregiver Support Coordinator (CSC). The date the application is received by VA is the date the application process begins. At this time VA does not provide the Program of Comprehensive Assistance for Family Caregivers to Veterans/Servicemembers and Family Caregivers living in a foreign country.

### SECTION I - VETERAN/SERVICEMEMBER

Last Name		First Name	Middle Name
Social Security Number	Date of Birth (mm-dd-yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Current Street Address			
City	State	Zip Code	
Telephone Number (Including Area Code)		Cell Number (Including Area Code)	
Email Address	Enrolled in VA Health Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Name of VA medical center or clinic where you receive or plan to receive health care services:

Name of facility where you last received medical treatment:  Hospital  Clinic

**Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting false, fictitious or fraudulent statements or claims**

*I certify that I give consent to the individual(s) named in this application to perform personal care services for me upon being approved as Primary and/or Secondary Caregiver(s) in the Program of Comprehensive Assistance for Family Caregivers.  
 I certify that the information above is correct and true to the best of my knowledge and belief.*

_____ Veteran/Servicemember/Representative/POA Signature	Date
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### SECTION II - PRIMARY FAMILY CAREGIVER

Last Name		First Name	Middle Name
Social Security Number	Date of Birth (mm-dd-yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Current Street Address			
City	State	Zip Code	

**SECTION II - PRIMARY FAMILY CAREGIVER (continued)**

Telephone Number (Including Area Code)		Cell Number (Including Area Code)	
E-mail Address		Relationship to Veteran (e.g., Spouse, Parent, Child, Other)	
Enrolled in Medicaid or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	

**Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting false, fictitious or fraudulent statements or claims**

*I certify that I am at least 18 years of age.*

Check one:

*I certify that I am a family member of the Veteran or Servicemember named in this application.*

OR

*I certify I am not a family member and I reside with the Veteran or Servicemember or will do so upon approval.*

*I agree to perform personal care services as the Primary Family Caregiver for the Veteran or Servicemember named on this application.*

*I understand that the Veteran may revoke my designation as Primary Family Caregiver at any time and that the Secretary of the Department of Veterans Affairs (or designee) may remove me from this position immediately if I fail to comply with the Program requirements as defined by law.*

*I understand that participation in the Program of Comprehensive Assistance for Family Caregivers does not create an employment relationship with the Department of Veterans Affairs.*

*I certify that the information above is correct and true to the best of my knowledge and belief.*

_____	
Primary Family Caregiver Signature	Date

**SECTION III - SECONDARY FAMILY CAREGIVER - Complete if appointing a Secondary Caregiver**

Last Name	First Name	Middle Name
Social Security Number	Date of Birth (mm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Current Street Address		
City	State	Zip Code

Telephone Number (Including Area Code)		Cell Number (Including Area Code)	
Email Address		Relationship to Veteran (e.g., Spouse, Parent, Child, Other)	

**Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting false, fictitious or fraudulent statements or claims**

**SECTION III - SECONDARY FAMILY CAREGIVER (Continued)**

*I certify that I am at least 18 years of age.*

Check one:

*I certify that I am a family member of the Veteran or Servicemember named in this application.*

OR

*I certify I am not a family member and I reside with the Veteran or Servicemember or will do so upon approval.*

*I agree to perform personal care services as the Secondary Family Caregiver for the Veteran or Servicemember named on this application.*

*I understand that the Veteran may revoke my designation as Secondary Family Caregiver at any time and that the Secretary of the Department of Veterans Affairs (or designee) may remove me from this position immediately if I fail to comply with the Program requirements as defined by law.*

*I certify that the information above is correct and true to the best of my knowledge and belief.*

_____	Date
Secondary Family Caregiver Signature	

**SECONDARY FAMILY CAREGIVER - Complete if appointing more than one Secondary Caregiver.**

Last Name	First Name	Middle Name
Social Security Number	Date of Birth (mm-dd-yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Current Street Address		
City	State	Zip Code
Telephone Number (Including Area Code)	Cell Number (Including Area Code)	
Email Address	Relationship to Veteran (e.g., Spouse, Parent, Child, Other)	

**Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting false, fictitious or fraudulent statements or claims**

*I certify that I am at least 18 years of age.*

Check one:

*I certify that I am a family member of the Veteran or Servicemember named in this application.*

OR

*I certify I am not a family member and I reside with the Veteran or Servicemember or will do so upon approval.*

*I agree to perform personal care services as the Secondary Family Caregiver for the Veteran or Servicemember named on this application.*

*I understand that the Veteran may revoke my designation as Secondary Family Caregiver at any time and that the Secretary of the Department of Veterans Affairs (or designee) may remove me from this position immediately if I fail to comply with the Program requirements as defined by law.*

*I certify that the information above is correct and true to the best of my knowledge and belief.*

_____	Date
Secondary Family Caregiver Signature	