Department of Veterans Affairs

STATUS CHANGE

TO	FROM	REPORT (Check One) ☐ INITIAL ☐ SUPPLE-MENTAL

PART I - PERSONAL DATA

1. VETERAN'S NAME	2. CLAIM NO.	3. SOCIAL SECURITY NO.

4. HOSPITAL DOMICILARY OR NURSING HOME CARE (Check One)

A. HOSPITAL	B. DOMICILIARY	C. NURSING HOME
☐ VA ☐ NON-VA	☐	☐ VA ☐ NON-VA

PART II - MOVEMENT OR DISPOSITION (Check and indicate date of action)

DATE OF ADMISSION _____

DATE OF RELEASE OR OTHER ACTION _____

RELEASED

☐ REGULAR DISCHARGE (*Including termination of non-bed care*)

☐ IRREGULAR DISCHARGE

☐ NON-BED CARE

☐ OUTPATIENT TREATMENT

☐ DIED

OTHER ACTION

☐ 1. TRANSFERRED TO: _____

☐ PLACED ON UNAUTHORIZED ABSCENCE

☐ PLACED ON NON-BED CARE FROM UNAUTHORIZED ABSENCE

☐ DATE SET FOR TERMINATION OF NON-BED ARE STATUS

☐ RETURNED FROM UNAUTHORIZED ABSENCE

☐ RETURNED TO BED CARE FROM NON-BED CARE STATUS

DOMICILIARY - NURSING HOME

☐ AUTHORIZED ABSENCE - 30 DAYS OR LONGER

☐ RETURNED FROM SUTHORIZED ABSENCE - 30 DAYS OR LONGER

PART III - CONDITION AT DISCHARGE

IS VETERAN CAPABLE OF RETURNING TO FULL EMPLOYMENT IMMEDIATELY?	IS PERIOD OF CONVALESCENCE REQUIRED FOR VETERAN?
☐ YES ☐ NO	☐ YES *(If "Yes," how long?)* _____ ☐ NO

PART IV- INFORMATION FOR VETERANS SERVICES DIVISION

DESTINATION OF PATIENT *(Address)*	NAME AND ADDRESS OF PERSON AGREEING TO PROVIDE SUPERVISION	
IF COMMITTED, INDICATE COMMITMENT COURT AND LOCATION	**DATE COMMITTED**	**CURRENT BALANCE OF FUNDS ON DEPOSIT IN PFOP**

PART V- ASSEST INFORMATION

FUNDS ON DEPOSIT	AMOUNT	LIST OF OTHER ASSESTS	ASSESTS ON VA FORM 10-7131
GRATUITOUS			
OTHER			
TOTAL			

PART VI- CERTIFICATION OF 21 DAYS CONSECUTIVE HOSPITALIZATION

Current medical records show the veteran was hospitalized for 21 consecutive days from _____ to _____

for treatment or observation of *(state diagnosis(es))*

and his presence is still required in the hospital for these conditions.

PART VII- REMARKS

SIGNATURE *(Chief, Medical Administration)*	DATE