|  |  |
| --- | --- |
| **Department of Veterans Affairs** | **VA Grant and Per Diem Program****Per Diem Only (PDO) Payment Voucher** |
| The Per Diem Payment Voucher is to be used after the recipient is determined eligible for per diem payments and should be submitted monthly to the VA Liaison. Who in turn will forward it to the GPD National Program Office at GPDvouchers@va.gov.  |
| **PROGRAM NAME AND ADDRESS:** | **DATE:** |
| **FAIN / PROJECT NUMBER:** |
| **PO NUMBER:** | **BILLING PERIOD: *(mm/dd/yy to mm/dd/yy)*** |
| **BILLING AMOUNTS -** Complete the appropriate sections below |
| **Supportive Housing:** The rate of per diem payments for each veteran in supportive housing shall be the lesser of (i) The daily cost of care estimated by the per diem recipient minus other sources of payments to the per diem recipient for furnishing services to homeless veterans that the per diem recipient certifies to be correct (other sources include payments and grants from other departments and agencies of the United States, from departments of State and local governments, from private entities or organizations, and from program participants), or (ii) The current VA State Home Program per diem rate for domiciliary care. |
| **HOUSING MODEL** | **TOTAL BED DAYS OF CARE PROVIDED, BY MODEL** | Per the FY 2020 NOFA, applicants funded for multiple models are authorized, without a change of scope, to flex between the applicant's authorized models up to five (5) beds per grant award at the same VAMC. | **BEDS AWARDED** |
| **Bridge Housing** |  |  |
| **Clinical Treatment** |  |  |
| **Hospital to Housing** |  |  |
| **Low Demand** |  |  |
| **Service-Intensive** |  |  |
|  | **TOTAL BED DAYS OF CARE PROVIDED** | **MULTIPLIED BY PER DIEM RATE**  | **EQUALS** | **TOTAL AMOUNT REQUESTED** | **AMOUNT PAID BY VAMC** |
| **GPD VETERANS**  |  |  | **=** |  |  |
| **MINOR DEPENDENTS (≤ 50% Per Diem)** |  |  | **=** |  |  |
| **GRAND TOTAL** |  |
| **VALIDATION -** Complete the appropriate sections below: |
| **GPD GRANTEE AUTHORIZED AGENT SIGNATURE:** To the best of my ability I certify the billing requested is accurate, based on actual costs, and when divided does not exceed 100% of the daily cost of care, per veteran, per day. |
| **NAME**  | **TITLE**  | **DATE**  |
| **SIGNATURE** |  |
| **VA GPD LIAISON VALIDATION SIGNATURE:** To the best of my ability I certify the billing is accurate and the funds paid are for the bed days of care that have been provided. |
| **NAME**  | **TITLE**  | **DATE**  |
| **SIGNATURE** |  |
| **After completion, email to: Grant and Per Diem Program Office @** **GPDVouchers@va.gov****NOTE: Liaisons, when sending completed voucher to GPD Office, the daily census should not be included.** |

VA FORM **10-0361D**

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