

**DEPARTMENT OF VETERANS AFFAIRS LIAISON FOR HEALTH CARE
STATIONED AT MILITARY TREATMENT FACILITIES**

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes procedures in the transition of health care of ill or injured active duty Servicemembers, mobilized Reservists, mobilized National Guard, and Veterans as they transition from the Department of Defense (DoD) to the Department of Veterans Affairs (VA) system of care.
- 2. SUMMARY OF MAJOR CHANGES:** The most significant changes include expanding the scope beyond combat ill or injured and training accidents to include other active duty military personnel and Veterans who are ill or injured and transitioning to VA health care. This revision also includes the Interagency Complex Care Coordination requirements (see appendix A for Interagency Complex Care Coordination definitions).
- 3. RELATED ISSUES:** VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans; Memorandum of Understanding between the VA and DoD for Interagency Complex Care Coordination Requirements for Servicemembers and Veterans and VA Directive 0007 Interagency Coordination of Complex Care, Benefits and Services.
- 4. RESPONSIBLE OFFICE:** The Chief Consultant, Care Management and Social Work Services (10P4C), Office of Patient Care Services, is responsible for the contents of this directive. Questions are to be referred to VA Liaison National Program Manager at 202-461-6065.
- 5. RESCISSION:** VHA Handbook 1010.02, dated November 13, 2009 is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of January 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publication Distribution List on January 31, 2017.

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**DEPARTMENT OF VETERANS AFFAIRS LIAISON FOR HEALTH CARE
STATIONED AT MILITARY TREATMENT FACILITIES**

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes procedures in the transition of health care of ill or injured active duty Servicemembers, mobilized Reservists, mobilized National Guard, and Veterans referred directly from Military Treatment Facilities (MTFs) to the Department of Veterans Affairs (VA) healthcare system. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1706 and 1710.

2. BACKGROUND

a. Since 2003, VA has collaborated with the Department of Defense (DoD) to transition the health care of ill or injured active duty Servicemembers and Veterans from MTFs to VA facilities by assigning VA Liaisons for Health Care at major MTFs (see appendix A) (may be referred to as VA Liaisons throughout this document). VA Liaisons ensure clear and timely communication with the Servicemember/Veteran and family, within the care management team, and across both DoD and VA care locations to support a successful transition of care. VA Liaisons assist with transfers to VA facilities and provide information to Servicemembers, Veterans, and families about VA health care services as well as onsite consultation and collaboration with DoD treatment teams regarding VA resources and treatment options. While the VA Liaison program was originally established to transition military personnel returning from theaters of combat, VA Liaisons now transition other active duty military personnel and Veterans who are ill or injured and transitioning to VA.

b. The National Defense Authorization Act (NDAA) 2008, Section 1611 required DoD/VA to develop and implement policy on the care, management, and transition of their wounded, ill and injured Servicemembers and Veterans. In 2012, the former Joint Executive Committee (JEC) approved the establishment of a joint DoD/VA commitment to implement the Warrior Care Coordination Task Force recommendation to develop and implement an interagency overarching policy for a common model of complex care coordination for seriously and catastrophically ill and injured Servicemembers and Veterans. The JEC established the Interagency Care Coordination Committee (IC3) to oversee efforts in accordance with the VA and DoD Secretaries' objectives to support "One Mission-One Policy-One Plan." The Memorandum of Understanding (MOU) between the VA and DoD for Interagency Complex Care Coordination Requirements for Servicemembers and Veterans represents the commitment and importance of the Departments' effort to implement a joint, patient-centered, standard model for coordinating all aspects of interagency and interdisciplinary complex care. This includes the assignment of a Lead Coordinator to assume the responsibility for coordinating benefits, and services for Servicemembers and Veterans requiring complex care coordination. Placement of VA Liaisons for Healthcare at MTFs is integral to the care, management, and transition of wounded, ill and injured Servicemembers and Veterans. VA Liaisons are uniquely positioned to coordinate care and improve transitions.

c. This directive describes the role of the VA Liaison for Health Care stationed at designated MTFs who coordinate the transition of health care of wounded, ill or injured active duty Servicemembers, mobilized Reservists, mobilized National Guard, and Veterans into the VA health care system. This includes military personnel who were injured while in support of combat operations, military personnel injured in training accidents while on active duty, as well as other active duty military personnel and Veterans who are ill or injured and transitioning to VA. **NOTE:** *Servicemember will be used to refer to active duty component, as well as Reserve component and National Guardsman currently on active duty orders as established by DoD.*

d. The intent of the directive is to establish practice standards, roles, responsibilities, and training requirements for masters-prepared social workers (MSWs) and registered nurses (RNs) who function as VA Liaisons for Healthcare.

3. POLICY

It is VHA policy to ensure that wounded, ill or injured active duty Servicemembers, mobilized Reservists, mobilized National Guard, and Veterans transitioning into the VA health care system receive transition assistance and care coordination. The complex medical, mental health, and psychosocial needs of transitioning Servicemembers and Veterans requires a skill set and knowledge base of Master's level, licensed health care professionals serving as a VA Liaisons for Healthcare. Additionally, VA Liaisons are integrated with DoD clinical teams and provide onsite clinical consultation and education to DoD clinical staff.

4. RESPONSIBILITIES

a. **Under Secretary for Health.** In collaboration with DoD, the Under Secretary for Health, or designee, is responsible for ensuring that full-time MSWs and RNs are appointed as VA Liaisons for Healthcare for major MTFs to:

(1) Assist with the transition of care to a VA medical facility.

(2) Provide on-site education at the MTF to active duty Servicemembers, Veterans, their families, and caregivers as well as MTF staff about VA health care services.

(3) Document all pertinent transition information in the Computerized Patient Record System (CPRS).

NOTE: *Although the VA Liaisons report administratively to the VA Medical Center closest to the MTF, they report programmatically to Care Management and Social Work Services (10P4C), Office of Patient Care Services, VA Central Office. The assignment of a VA Liaison to additional MTFs will be determined collaboratively between DoD and 10P4C and the Deputy Under Secretary for Health for Operations and Management (10N). The number of VA Liaison positions at each MTF will be based on workload.*

b. **VA Liaison National Program Manager.** The VA Liaison National Program Manager is assigned to 10P4C and is accountable for ensuring that the VA Liaison

Program is standardized nationally with consistent policies and procedures across the program. The VA Liaison National Program Manager is responsible for:

- (1) Standardizing the process and procedures for the VA Liaisons nationally and maintains standardized functional statements.
 - (2) Providing salient direction and guidance to the VA Liaisons on a regular basis. Provides input into the VA Liaisons' annual performance evaluation.
 - (3) Providing orientation and training to new VA Liaisons.
 - (4) Providing ongoing education and training on updated policies and procedures to VA Liaisons.
 - (5) Collaborating with DoD to ensure effective incorporation of VA Liaisons at identified MTFs.
 - (6) Collaborating with the Office of the Deputy Under Secretary for Health for Operations and Management when placing VA Liaisons at MTFs.
 - (7) Moderating regular national conference calls for all VA Liaisons.
 - (8) Advocating for the VA Liaison with DoD as well as senior and local VA leadership to ensure the VA Liaison has the support and resources needed to fulfill the role. This includes but is not limited to office space, phone, equipment, and appropriate identification cards to access buildings and computer systems, etc.
 - (9) Standardizing the documentation in CPRS via a national template available on the Health Information Management website at https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco_HIM/subsite5/subsite3/Health%20Record%20Resources/Forms/AllItems.aspx?RootFolder=%2Fsites%2FHDI%2FHIM%2Fvaco%5FHIM%2Fsubsite5%2Fsubsite3%2FHealth%20Record%20Resources%2FCPRS%2FDocumentation%2OTemplates&FolderCTID=0x0120003FCF0C5072A8F94EABBD0A02C88A0D0B&View={FC2D1DD9-3A32-487D-905C-32225E1A22EE}
- NOTE:** *This is an internal VA Web site that is not available to the public.*

c. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for:

- (1) Ensuring RNs or MSWs are assigned to serve as VA Liaisons for Healthcare at designated MTFs, as directed by 10P4C, Office of Patient Care Services, VHA, VA Central Office.
- (2) Ensuring that appropriate care transitions and health care services are provided to Servicemembers and Veterans in a timely manner when requested by and coordinated with VA Liaisons.

d. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Assigning RNs or MSWs to serve as VA Liaisons for Healthcare at designated MTFs, utilizing the nationally standardized functional statements, as directed by 10P4C. VA Liaisons for Healthcare will be assigned at a minimum at the locations specified in appendix B. **NOTE:** *The VA Liaison reports directly to the medical facility Director, or designee. Requests for additional VA Liaisons need to be directed to the VA Liaison National Program Manager in coordination with 10N and the VISN.*

(2) Providing health care services to authorized Servicemembers and eligible Veterans when requested and in a timely manner. Ensuring VA medical facility staff, both administrative and clinical, are educated and authorized to provide health care services to eligible transitioning Servicemembers and Veterans when requested by the VA Liaison.

(3) Providing VA Liaisons with the resources and support necessary to fulfill the duties of the VA Liaison position.

(4) Ensuring the national VA Liaison note template is loaded into the CPRS at the local VA medical facility.

(5) Ensuring that all personnel actions for the VA Liaisons including hiring actions and professional credentialing, competencies, and scope of practice as appropriate are carried out.

e. **VA Liaison for Health Care.** The primary role of the VA Liaison for Health Care is to facilitate the transfer of health care, both inpatient and outpatient, from MTFs to the appropriate VA medical facility. VA Liaisons for Health care are independent clinical practitioners, working closely with both DoD and VA care management teams using advanced practice skills and expertise to provide ongoing consultation regarding complex discharge planning issues, VHA health care benefits, resources, and facilities. This will require an intimate knowledge of both DoD and VHA programs and services nationwide, and the ability to match Servicemembers' and Veterans' needs with appropriate resources to mitigate risk and optimize care transition. The responsibilities of the VA Liaison include:

(1) Meeting with the Servicemember, Veteran, family, and caregiver to provide education and an overview of VHA health care benefits and resources to address current medical issues identified as part of the Servicemember's treatment plan. As a member of the care management team, the VA Liaison will provide contact information for the Transition and Care Management (TCM) Program Manager and Lead Coordinator, if applicable, at the receiving VA medical facility. In collaboration with the MTF treatment team, the VA Liaison must consider the Servicemember and family's psychosocial situation, their ability to comprehend and comply with a VA treatment plan, and any special needs of the Servicemember, Veteran, family, and caregiver that may impact reaching optimal psychosocial functioning. The VA Liaison, in conjunction with

the Lead Coordinator, if applicable, ensures the Servicemember, Veteran, family, and caregiver are fully informed and understand the plan for transition and initial VA plan of care. **NOTE:** *Regular onsite collaboration and coordination at the MTF is crucial to provide effective consultative services and the referral, linkage, education, and assessment functions. The provision of direct services is necessary to enhance the communication and relationship with Servicemembers, Veterans, their families, and caregiver.*

(2) Providing onsite VA expertise at the MTF and educating treatment teams on the specialized care, benefits, and services provided in the VA Health Care system to optimize the transition planning for Servicemembers. This requires extensive knowledge of both VA and DoD systems, processes, and terminology.

(3) Collaborating with the MTF treatment team to provide ongoing clinical consultation regarding complex discharge planning issues, VHA health care benefits and resources, and identifying the VHA facility where the Servicemember/Veteran will be transferred. VA Liaisons actively participate in interdisciplinary discharge and treatment planning, understand each Servicemember's/Veteran's individual treatment plan, and synthesizes this information into coordinating ongoing VA health care.

(4) Developing relationships and collaborating with the MTF social workers, case managers, specialty care staff, managed care staff, discharge planners, Warrior Transition Unit, and Brigade or Medical Holding Company staff, where applicable, to identify Servicemembers and Veterans ready for discharge to VHA, and obtain clear referral information and authorization for VHA to treat those still on active duty. The referral needs to:

(a) Clearly identify the Servicemember's and Veteran's diagnoses, health care and psychosocial needs, and requests for VHA health care services.

(b) Include the VA Form 10-0454 Referral (see appendix B) and pertinent MTF medical records, such as the admission sheet, history and physical and daily clinical notes for inpatients, or recent outpatient clinical notes.

(c) If the Servicemember is still active duty, include clinical orders from an MTF clinician specifying which services are authorized for VHA to provide. In addition, the referral must include verification that TRICARE or other appropriate authorization has been requested, i.e., Military Medical Support Office (MMSO), TRICARE Managed Care Support Contractor (MCSC), or VA and DoD Sharing Agreement. **NOTE:** *If the Servicemember will be discharged from active duty prior to the time of the first appointment at the VA medical facility, no TRICARE authorization will be needed.*

(5) Coordinating referrals from non-clinical sources such as Veterans Benefits Administration, Integrated Disability Evaluation System (IDES), DoD Wounded Warrior Support Programs, and self-referrals from transitioning Servicemembers.

(6) Ensuring, through direct coordination with the Eligibility, Business Office, and Enrollment Coordinator, or designated point of contact, that all referrals and

authorizations are entered into CPRS at the Liaison's home facility. It is expected for Servicemembers and Veterans to be registered or enrolled in the VA Liaison's home facility CPRS within 72 hours after the receipt of the referral. The VA Liaison needs to coordinate with their Eligibility, Business Office, and Enrollment Coordinator or designated point of contact to securely transfer this information via *Patient Data Exchange (PDX)* or in accordance with VA and Health Insurance Portability and Accountability Act (HIPAA) security policies to the receiving VA medical Veterans Health Information Systems and Technology Architecture (VistA) and CPRS.

(7) Identifying and communicating with the receiving VA TCM Program Manager, and if indicated, a specialty program admissions coordinator, i.e., Polytrauma Rehabilitation Center (PRC), Spinal Cord Injury Rehabilitation Center, etc., at the receiving VA medical facility via telephone and encrypted email to initiate the requested health care.

(a) The VA Liaison must transmit the referral form and pertinent health records to the TCM Program Manager and admissions coordinator via fax or encrypted electronic mail attachment.

(b) Outpatient appointments need to be given to the Servicemember or Veteran prior to leaving the MTF, however, it must be for a date after their expected discharge or release from the military or appropriate TRICARE authorization is required, as per below:

1. Appointments that will occur after the Servicemember or Veteran is discharged from active duty and is a Veteran need to be made in advance while a Servicemember or Veteran is still on active duty.

2. If the appointments are not available at the time the Servicemember or Veteran is leaving the MTF, the VA Liaison must make arrangements for the Servicemember or Veteran to be notified. The VA Liaison or care management team member must contact the Servicemember or Veteran with the appointment information.

3. If the Servicemember or Veteran will still be on active duty at the time of any appointments, TRICARE authorization will be required and the Liaison needs to assist in obtaining clinical orders from a MTF clinician to obtain TRICARE authorization for the appointment(s). There must be a designated person at the receiving VA medical facility to then acquire the required authorization number from the MTF initiating the referral or the MCSC. If the transitioning Servicemember will be in Veteran status at the time of the appointment, no TRICARE authorization is needed to access care.

(8) Linking Servicemembers, Veterans, families, and caregivers with appropriate providers and resources across the care setting and ensuring the receiving VHA facility TCM Program Manager or specialty program admissions coordinator has contact information for pertinent DoD points of contact, i.e., military Lead Coordinator, military case manager, Warrior Transition Unit (WTU) case manager, etc., needed for ongoing communication and collaboration about a Servicemember's or Veteran's health care.

(9) Facilitating the identification and communication between the transferring and receiving Lead Coordinators for those SM/V with complex care coordination needs, by providing the DoD Lead Coordinator's name and contact information as well as the interagency comprehensive plan and checklist to the receiving TCM Program Manager. When the VA Lead Coordinator is assigned, the VA Liaison will provide the VA Lead Coordinator name and contact information to the DoD Lead Coordinator facilitating communication between the transferring and receiving Lead Coordinators.

(10) Serving as an onsite resource at the MTF for VA treatment teams needing to connect with MTF staff in order to transfer a Servicemember or Veteran from a VA medical facility to the MTF and helping to identify appropriate MTF treatment team members to facilitate the transition.

(11) Addressing any barriers to health care and communicating those barriers to the TCM Program Manager or specialty program admissions coordinator to reduce or eliminate these barriers as appropriate.

(12) Documenting all VA Liaison activity as follows:

(a) Every referral will be documented in CPRS using the appropriate national templates available on the Health Information Management website at https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco_HIM/subsite5/subsite3/Health%20Record%20Resources/Forms/AllItems.aspx?RootFolder=%2Fsites%2FHDI%2FHIM%2Fvaco%5FHIM%2Fsubsite5%2Fsubsite3%2FHealth%20Record%20Resources%2FCPRS%2FDocumentation%20Templates&FolderCTID=0x0120003FCF0C5072A8F94EABBD0A02C88A0D0B&View={FC2D1DD9-3A32-487D-905C-32225E1A22EE}.

NOTE: This is an internal VA Web site and is not available to the public.

(b) Every referral will be registered in the Federal Case Management Tool (FCMT).
NOTE: Severely Ill and injured or Non-severely Ill and Injured must be indicated within FCMT. The designation of Severely Ill and Injured will trigger a performance measure for the receiving VA medical.

(c) Each week, the VA Liaison will document workload in the workload activity log in FCMT, which is monitored by VA Central office.

(13) Maintaining a relationship and collaborating where applicable with Federal Recovery Coordinators (FRCs) on-site at the MTF. If a transitioning Servicemember requiring complex care coordination does not have an FRC, VA Liaisons may make a referral to FRC program when appropriate.

(14) Maintaining a relationship where applicable with the Veterans Benefits Administration (VBA) staff on-site at the MTF.

(15) Representing VHA at the MTF on a global, non-patient specific basis at briefings, participating in educational opportunities, meeting with the MTF Command, etc.

(16) Reporting programmatically to the VA Liaison National Program Manager, Care Management and Social Work Services, in VA Central Office. This includes, but is not limited to:

- (a) Implementing the national standardized procedures of the VA Liaison Program.
- (b) Reporting programmatic issues directly to the VA Liaison National Program Manager in a timely fashion.
- (c) Responding to regular direction and requests from the VA Liaison National Program Manager.
- (d) Participating in regular national conference calls for VA Liaisons.
- (e) Participating in special projects as needed by the VA Liaison National Program.
- (f) Informing the VA Liaison National Program Manager, as well as local leadership, of any high profile or high priority issues that may be of interest to VA Central Office leadership.
- (g) Participating in the national VA Liaison peer review process.

VA/DOD COMPLEX CARE COORDINATION DEFINITIONS

1. **Care Management Team (CMT).** The CMT includes individuals who are working together to manage, coordinate, and/or deliver the care, benefits, and services for the SM/V and to support the family or caregiver. The professions and individuals who comprise a specific CMT will vary based on the needs of the individual and their family or caregiver (e.g. health care provider(s), attending physician, nurse case manager, therapist, social worker, vocational rehabilitation specialist, Command representative, and all others providing care, benefits, and services, including military or community resources). The most appropriate CMT member already providing health care, benefits, or services, will serve as the Lead Coordinator (LC) and direct complex care coordination efforts.
2. **Complex Care Coordination.** Complex care coordination involves assisting the most severely wounded, ill, or injured SM/Vs, or those SM/Vs with complex circumstances. The SM/Vs that meet the criteria for complex care coordination, are expected to have a prolonged recovery or rehabilitation process, and may require access to clinical, social, educational, financial, and other services across various organizations and providers. The objective of the interdisciplinary complex care coordination team model is to establish and optimize the use of the Interagency Comprehensive Plan (ICP) and the resulting application of care, benefits, and services, including military and community resources, to facilitate and promote the SM/V's recovery or return to as high a level of function as achievable.
3. **Interagency Comprehensive Plan (ICP).** The ICP is a SM/V-centered recovery or rehabilitation plan with identified goals for recovery and rehabilitation to ongoing care and community reintegration. The plan is developed from a comprehensive needs assessment, which identifies the recovering SM/V's personal and professional needs and goals with input from their family or caregivers and the services and resources needed to achieve them through specific activities in those key areas, which were reviewed during assessment.
4. **Lead Coordinator (LC).** The LC is a role for an existing member of the CMT who, while fulfilling their responsibilities of their primary role, assumes responsibility for coordinating the development and overseeing execution of the ICP, but the LC is not responsible for the actual delivery of care beyond their scope of practice. The LC facilitates communication and serves as the primary point of contact to the SM/V and family or caregiver, as well as the rest of the CMT, in order to avoid or reduce confusion. Lead Coordinators can be clinical or non-clinical, and are co-located with the recovering SM/V when feasible.

MILITARY TREATMENT FACILITIES WITH DEPARTMENT OF VETERANS AFFAIRS
(VA) LIAISONS STATIONED ON-SITE

18 VAMCs	21 MTF LOCATIONS	# OF VA LIAISONS*
Augusta, GA VAMC	Dwight David Eisenhower Army Medical Center (DDEAMC), Ft. Gordon, GA	2
Alexandria LA VAMC	Bayne Jones Army Community Hospital, Fort Polk, LA	1
Central Alabama VA HCS	Martin Army Community Hospital (MACH), Ft. Benning, GA	2
Central Texas VA HCS	Carl R. Darnall Army Medical Center (CRDAMC), Ft. Hood, TX	3
Charleston, SC VAMC	Winn Army Community Hospital (WACH), Ft. Stewart, GA	2
Eastern Colorado VA HCS	Evans Army Community Hospital (EACH), Ft. Carson, CO	2
Eastern Kansas HCS	Irwin Army Community Hospital (IACH), Ft. Riley, KS	2
El Paso, TX VA HCS	William Beaumont Army Medical Center (WBAMC), Ft. Bliss, TX	1
Fayetteville, NC VAMC	Camp Lejeune Naval Medical Hospital, Camp Lejeune, NC	1
	Womack Army Medical Center (WAMC), Ft. Bragg, NC	2
Hampton, VA VAMC	McDonald Army Health Center (MCAHC), Ft. Eustis, VA	1
Honolulu HI VAMC	Tripler Army Medical Center (TAMC), Honolulu, HI	1
Louisville, KY VAMC	Ireland Army Community Hospital (IACH), Ft. Knox, KY	2
Puget Sound VA HCS	Madigan Army Medical Center (MAMC) / Joint Base Lewis-McChord (JBLM), Ft. Lewis, WA	3
San Diego, CA VAMC	Naval Hospital Camp Pendleton (NHCP), Camp Pendleton, CA	2
	Naval Medical Center, San Diego (NMCSD), San Diego, CA	2
South Texas VA HCS	San Antonio Military Medical Center (SAMMC)	4
	Center for the Intrepid (CFI), Ft. Sam Houston, TX	
Syracuse, NY VAMC	US Army Medical Department Activity (USAMEDDAC), Ft. Drum, NY	2
Tennessee Valley VA HCS	Blanchfield Army Community Hospital (BACH), Ft. Campbell, KY	2
Washington, DC VAMC	Walter Reed National Military Medical Center (WRNMMC), Bethesda, MD	4
	Ft Belvoir Community Hospital (FBCH), Ft. Belvoir, VA	2

As of September 1, 2016

* The number of VA Liaisons at each MTF will be based on workload and may change due to fluctuations in MTF populations.

NOTE: The Transition and Care Management Program Manager at the receiving VA medical facility can be contacted directly for referrals from MTFs where there is no VA Liaison located on-site.

January 27, 2017

VHA DIRECTIVE 1011
APPENDIX C

**DEPARTMENT OF VETERANS AFFAIRS (VA) FORM 10-0454, MILITARY
TREATMENT FACILITY REFERRAL TO VA**

Department of Veterans Affairs (VA) Form 10-0454, Military Treatment Facility Referral to VA, is available on the VA Internet forms Web site <http://www.va.gov/vaforms> and VA forms Intranet Web site <http://vaww.va.gov/vaforms> (**NOTE:** *This is an internal VA Web site and is not available to the public.*)