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88TH LEGISLATIVE SESSION

THE SELECT COMMITTEE ON VETERANS HOUSING

FINAL REPORT

Recommendations Submitted to the Minnesota State Legislature

December 2013

INTRODUCTION:

At the end of the 2013 legislative session, the state passed an $18.9 million bonding bill to fund one-third of the cost of the third and final phase of renovations and buildings at the Minneapolis State Veterans Home. During session, two other bills were presented: one by Rep. John Ward for a state veterans home (SVH) in Brainerd and the other offered by Rep. John Persell for a similar home in Bemidji. Minnesota Department of Veterans Affairs (MDVA) had previously applied for a federal Veterans Administration (VA) funding match for a home in Willmar and a home in Montevideo, but state money has yet to be appropriated for either of these projects. Interest in securing a SVH in Preston and Rochester was expressed during session, respectively, by Rep. Greg Davids and Rep. Kim Norton; however these bills were not passed by the legislature. Issues raised throughout the 2013 session included: which proposed SVH should receive state funding, where future SVH should be located, and how existing and future homes should be funded. The 2009 MDVA Community Identification Study for a New Minnesota Veterans Home was frequently cited. This study, requested by the legislature and commissioned by MDVA, had been conducted to determine what criteria should be considered in the selection of a site for a new SVH and identified 17 potential communities that met the minimum criteria for a SVH. MDVA has since testified that the original study was flawed and a new study that focuses on issues relevant to federal funding qualifications should be done.

In May 2013 Rep. Paul Thissen, Speaker of the House, announced the formation of the Speaker's Select Committee on Veterans Housing. The committee was to "examine housing issues facing Minnesota veterans, including veterans with long-term care needs and homeless veterans. The Select Committee will hold hearings over the interim and may tour Minnesota's veterans homes in order to recommend policies that assure safe, high-quality, cost-effective housing for veterans in our state. The committee will issue a report with their recommendations by February 1, 2014."

The committee was chaired by Rep. Jerry Newton. Members included Rep. Mary Murphy and Rep. Bob Dettmer, chair and GOP lead of the State Government and Veterans Affairs Finance Committee; Rep. Alice Hausman and Rep. Matt Dean, chair and GOP lead of the Capital Investment Committee; Rep. Tom Huntley and Rep. Jim Abeler, chair and GOP lead of the Health and Human Services Finance Committee; and Rep. Karen Clark and Rep. Paul Anderson, chair and GOP lead of the Housing Finance and Policy Committee.

VETERANS HOMES AND REGIONAL VA MEDICAL CENTERS:

Minnesota's five veterans homes are run by the Minnesota Department of Veterans Affairs (MDVA) and currently provide skilled nursing care, domiciliary care, and Adult Day Center services to approximately 825 veterans and nonveteran spouses. There are currently 790 beds in operation and 35 slots available at the Adult Day Center in Minneapolis. The state veterans homes are anticipated to have 890 beds in operation after Phase 3 of the Minneapolis veterans home is completed. The federal cap on state veterans home beds is currently set at 1058.

The Minnesota Soldiers' Home was established in 1887 in Minneapolis by the Minnesota legislature to assist in the care of Civil War veterans and other soldiers who had fought in armed conflict and who did not have the means to care for themselves and were in need of assistance.[1] (See Appendix A) The home originally provided domiciliary[2] care and attended to only minimal medical needs. In the 1970s the home began to provide some skilled nursing care. The Hastings domiciliary was established in 1978 with 200 domiciliary beds. In 1978 the Minneapolis home had 250 skilled nursing beds and 250 domiciliary beds. The Silver Bay home with 83 skilled nursing beds opened in 1991. The Luverne home with 85 skilled nursing beds opened in 1994. The Fergus Falls home, which now has 101 skilled nursing home beds, opened in 1998. In 2002, the Minnesota legislature approved funding for construction of an Adult Day Center at the Minneapolis Veterans Home. In May of 2010, the federal VA provided a 65% match of $3.2 million for the funding and in 2012, the Minneapolis Veterans home campus opened an Adult Day Center that can accommodate up to 35 veterans in an adult day health care program to provide respite for families and caregivers. In 2013, the has been a daily average of 13 veterans in the program.

In recent years updates have been requested and funding approved to maintain and expand the Minneapolis State Veterans Home. This included a three phase project that expands the number of skilled nursing home beds, rebuilds facilities to the specifications of the VA, qualifies certain buildings on the campus for Medicaid and Medicare, and integrates and updates food service, information technology, and the pharmacy at the home. The capital expenditures for the Minneapolis home since 1987 have been approximately $81.8 million. The federal contribution in matching grant funds has been approximately $48.3 million[3], for a total of $130 million dollars. The state is still waiting to hear if the final federal request for $31.16 million to complete phase 3 of the project is going to be awarded by the federal VA, and if that award is made that will bring the total capital expenditures for the Minneapolis Veterans Home to approximately $161 million since 1987. The number of beds currently operating at the Minneapolis Veterans Home is down 159 beds since 1978.

The federally operated Minneapolis VA Medical Center, located near the State Veterans Home in Minneapolis, offers various programs to assist homeless veterans and also provides long-term care to veterans eligible for their programs. (See Appendix B) The long-term care provided by the VA Medical Center includes skilled-nursing care at the 74-bed community living center, rehabilitation services, hospice and palliative care, and the medical foster home program. The VA also contracts with community nursing homes to provide care for eligible veterans, and

[1] MDVA, History of the State Veterans Homes, http://mn.gov/mdva/homes/vethomeshistory.jsp.

[2] The term domiciliary is used by the federal VA and defined as: "providing shelter, food, and necessary medical care on an ambulatory self-care basis (this is more than room and board). It assists eligible veterans who are suffering from a disability, disease, or defect of such a degree that incapacitates veterans from earning a living, but who are not in need of hospitalization or nursing care services. It assists in attaining physical, mental, and social well-being through special rehabilitative programs to restore residents to their highest level of functioning." 38 C.F. R. 59.2.

[3] $46.5 million in federal contributions is the amount identified through MDVA records and the current accounting system. There may be additional federal contributions that could not be easily identified by the current accounting system.

currently has approximately 60 contracts with community nursing homes in Minnesota. There are different eligibility requirements for different programs through the VA medical center.

COMMITTEE MEETINGS AND ACTIVITIES:

Between May and November, the Chair held one-on-one meetings with representative of the Minnesota Department of Veterans Affairs (MDVA), the Department of Human Services, and private and nonprofit organizations. The Chair posed numerous questions to the House Research Department and fiscal staff and the MDVA Legislative Liaison to provide background information to committee members. In addition to committee visits to MDVA and nonprofit facilities in Minneapolis, Hastings, and Mankato, the Chair personally toured MDVA homes at Silver Bay and Fergus Falls and the 41-unit nonprofit Eagles Healing Nest at Sauk Center.

The House Select Committee on Veterans Housing toured the Minneapolis Veterans Home and the VA Medical Center in Minneapolis on August 7, 2013. Members and staff visited the VA medical center to see the community living center, hospice, and assisted living facilities. The staff at the VA hospital explained the programs available at the Minneapolis VA medical center as well as the contract nursing home program and the medical foster home program. Then committee members and staff toured the Minneapolis Veterans Home campus to see buildings that had been updated and buildings that were going to be replaced. MDVA Deputy Commissioner Michael Gallucci and staff answered questions about the homes and provided information to members about the proposed changes to the Minneapolis home and anticipated funding streams.

The committee was provided a memorandum from House Research on September 20, 2013, with background information on veterans housing programs as well as answers to some of the questions posed during the tour of the Minneapolis Veterans Home. The revised version, dated November 5, 2013, includes corrections, updates, and supplemental information that was either presented or requested during formal hearings. (See Appendix C)

Two hearings were held on October 1, 2013, and one hearing on the morning of October 2, 2013. The MDVA, the Minnesota Housing Finance Agency, and the Department of Human Services all presented testimony on issues such as veterans housing and long-term care. Interested community organizations and nonprofits were also present and provided information on programs and services. (See Appendix D)

On October 22, 2013, the committee and staff toured the Minnesota Assistance Council for Veterans (MACV) Radichel Townhomes, which provide permanent supportive housing to disabled veterans in Mankato. MACV presented an overview of the program and how the housing was developed for the 11-unit project. (See Appendix E)

Later that day, the committee toured the Minnesota Veterans Home in Hastings. The Hastings facility is operating a 180-bed domiciliary for veterans with mental health diagnosis, chronic substance abuse, and medical issues that require assistance with daily living and supportive

services. The program does not provide onsite chemical dependency treatment but instead coordinates with a nearby facility and the federal VA medical centers in St. Cloud and Minneapolis to provide that treatment. The Hastings home has eight mental health providers and a nursing staff to assist with medical conditions and mental health therapy. The facility has double-occupancy rooms and is paid for primarily with state funds and VA per diem reimbursements. The facility operates a five-bedroom transitional housing single-family residence for veterans to stay for up to one year when transitioning out of the home. The veterans pay rent of $250 a month to the Hastings transitional housing facility and receive supportive services while at the home.

FINDINGS:

Veterans Demographics and Minnesota:

1. Nationally, the overall population of veterans is decreasing and anticipated to decrease from just over 22 million in 2010 to near 15 million in 2040; however, within that decreasing population, the relative percentage of women and minority veterans is increasing (See Appendix F).[4]

2. The number of veterans in Minnesota is currently approximately 385,000, with veterans under 34 years of age making up just under 6% of the total veterans population. Veterans over 75 years of age make up less than 24% of the total veterans population in Minnesota.

Age of Veterans	**Population**[5]
18-34 years old	22,642
35-54 years old	90,255
55-64 years old	103,940
65-74 years old	77,174
75 + years	91,664
Total	385,675

3. The population of adults over the age of 65 and the population of adults over the age of 85 are both increasing more rapidly than the rest of the population and are expected to increase dramatically before 2040.[6]

[4] See also, Martha McMurry, "Veterans in Minnesota" Minnesota State Demographic Center, February 2009, http://www.demography.state.mn.us/documents/VeteransinMinnesota.pdf

[5] Minnesota Department of Veterans Affairs, Data and Statistics, State Veterans Population, using the 2007-2011 U.S. Census American Community Survey.

[6] Minnesota State Demographic Center, "Minnesota Population Projections 2015-2040," October 2012, http://www.demography.state.mn.us/PopulationPyramids2015-2040/Projecxtions2012Paper.pdf.

Homelessness and Veterans:

1. President Obama's Federal Strategic Plan to End Homelessness by 2020 and the Plan to End Veterans Homelessness by 2015 have focused federal attention to the issue of homelessness.

2. The Housing and Urban Development (HUD) Veterans Affairs Supportive Housing (VASH) program is operated by the VA and HUD to provide tenant-based housing vouchers to veterans, with the VA providing supportive services. The program has increased in recent years and currently Minnesota has 475 vouchers. (See Appendix G)

3. Minnesota's Interagency Council on homelessness also anticipates finishing the job of ending homelessness for veterans and for people experiencing chronic homelessness by 2015. The Council includes representatives from the following agencies: Minnesota Housing Finance Agency, Department of Human Services, Department of Veterans Affairs, Department of Education, Department of Employment and Economic Development, Department of Public Safety, Department of Health, Department of Human Rights, Office of Higher Education, Department of Corrections, and the Department of Transportation.

4. In Minnesota, the percentage of homeless adults who are veterans as part of the overall homeless population has been decreasing and is currently about 9%, similar to the overall veterans population in Minnesota. There were 580 homeless veterans counted in the 2012 Wilder Research study. (See Appendix H)

5. Homeless veterans face many of the same challenges as the general adult homeless population including: mental illness, chemical dependency, unemployment, physical disabilities, lack of access to health care, and health problems. (See Appendix H)

6. African American and American Indian veterans make up a disproportionate number of homeless veterans in Minnesota. Thirty-seven (37%) percent of homeless veterans are persons of color, and 33% of veterans in the Twin-Cities metro area were African American. (See Appendix H) The 2007-2011 American Community Survey shows that 95.6% of the Minnesota veterans population identifies as white (Caucasian), 1.9% identify as African American, 0.9% identify as American Indian, 0.5% as Asian or Pacific Islander, and 1.1% as Latino or Hispanic.

7. There are programs to assist homeless Minnesota residents with emergency, transitional, and long-term supportive housing. Some of these programs are exclusive to veterans. (See Appendix C)

8. Increased access to transitional housing programs with supportive services and long-term supportive housing would be needed to end homelessness in Minnesota for veterans.

9. The domiciliary in Hastings is a state veterans home that does not have skilled nursing care but is operated exclusively for veterans in need of assisted living for alcohol and chemical dependency, mental health, dual diagnosis, and physical health diagnosis. The domiciliary does not have a chemical health rehabilitation program licensed as a Rule 31 facility, but does work with a chemical dependency treatment program on the campus in Hastings and with the VA medical centers in Minneapolis and St. Cloud for chemical dependency treatment. The domiciliary in Hastings has a five-bedroom home used for transitional living for veterans leaving the facility.

10. The Minneapolis Veterans Home also has a 50-bed domiciliary in addition to 291 skilled nursing beds. It does not have transitional living accommodations for veterans leaving the domiciliary and instead utilizes transitional housing and halfway homes throughout the Twin Cities. Chemical and alcohol dependency treatment and mental health professionals are available through the VA medical centers in Minneapolis and Saint Cloud.

11. Minnesota Assistance Council for Veterans (MACV) is a private nonprofit providing care for disabled veterans and chronically homeless veterans in the 11-unit Radichel Townhomes in Mankato. MACV has other facilities providing long-term supportive housing and transitional housing to veterans in the Twin Cities metro area and Duluth. The Eagles Healing Nest is providing housing and supportive services in a 41-bed facility in Sauk Center. Both facilities are drug and alcohol free with limited staff and supportive services provided to assist veterans. Similar housing programs are operated by other nonprofit organizations in Minneapolis and Saint Cloud. MDVA operates the Minnesota Operation for Veterans Empowerment (M.O.V.E.) program which provides four beds at the Union Gospel Mission in St. Paul to veterans willing to work with the MDVA to receive supportive services. The emergency shelter is available for 30 days with a possible extension to 60 days and is funded through MDVA's State Soldiers' Assistance Program.

12. The federal and state efforts to end homelessness and the efforts of the nonprofits working on these issues have raised the importance of the issue of veterans homelessness and implemented plans and programs to further decrease the number of homeless veterans. Continuing monitoring and increased state and nonprofit funding will be required to ensure long-term success and the end to veterans homelessness.

13. Except for a need to provide more housing and services to homeless minority veterans, Minnesota has successful programs in place to house and serve homeless veterans and should continue to fund and monitor existing programs.

Veterans Long-Term Care and the State Veterans Homes:

Minnesota offers a liberal program of long-term care for veterans when compared with other states. Some states restrict long-term care exclusively to veterans who have served in combat, and other states do not allow for care for nonveteran spouses. (See Appendix I)

1. Minnesota's five veterans homes are run by the Minnesota Department of Veterans Affairs (MDVA) and currently provide skilled nursing care, domiciliary care, and Adult Day Center services to approximately 825 veterans and nonveteran spouses. There are currently 790 beds in operation and 35 slots available at the Adult Day Center in Minneapolis. The state veterans homes are anticipated to have 890 beds in operation after Phase 3 of the Minneapolis veterans home is completed. (See Appendix J)

2. The state is anticipating $36 million in federal funding for 65% of Phase 3 renovations and new construction for the Minneapolis Veterans Home. The $36 million is a match to the $18.9 million in state funding contained in the 2013 bonding bill. The federal funding represents the final funding source for completion of a three-phase project that adds 100 beds to the Minneapolis SVH and provides for a better integration of technology, food service, and medical assistance for patients. (See Appendix J)

3. Other than Phase 3 of the Minneapolis Veterans Home, there are no applications for veterans nursing homes pending at the federal level. There is a federal bed cap for VA reimbursement currently set for Minnesota at 1,058 beds. The cap can be exceeded only under certain circumstances or may be raised by the VA or through federal legislation. (See Appendix J)

4. Long-standing applications for homes in Montevideo and Willmar, as well as 2013 applications for homes in Brainerd and Bemidji, were all cancelled by MDVA in early April 2013. Those applications were cancelled because collectively they would have exceeded the 1,058-bed cap for Minnesota, as established by the VA; inasmuch all nursing home beds requested in the VA's queue counted against the total bed cap for the state. Without state funding, no new state veterans home projects would be considered for federal VA matching funds. Additional issues, including: the distance between proposed homes and existing homes, and the use of land leases in the four previous applications for new homes would preclude some of them from receiving federal VA funding without first securing a waiver. (See Appendix J)

5. MDVA has indicated that it is within the authority of the agency to apply for federal funding for state veterans homes, including new construction, remodeling, and the creation of new programs and facilities, without legislative approval.

6. Minnesota has a nursing home bed moratorium. However there is an exception in statute for state veterans homes. The state veterans homes should be able to be licensed by the state and able to complete their Centers for Medicare and Medicaid Services (CMS) certification, which would allow the SVHs to accept Medicare and Medicaid. MDVA has indicated some buildings will not be CMS certified as it would not be cost effective to remodel those facilities.

7. MDVA is moving towards CMS certification to accept Medicaid and Medicare payments for residents. The Minnesota Department of Health has sent the approval of Minneapolis SVH building 19 to CMS and is awaiting final approval from the CMS regional office in Chicago. Other buildings and homes will be sequenced toward CMS certification so as not to overly disrupt MDVA which has to update policies and procedures during the transition. (See Appendix J)

8. Minnesota has had a continual drop in nursing home occupancy levels and has the lowest recorded rate of nursing home occupancy at 90% for community based nursing homes.

9. The cost of providing medical services or skilled nursing care to patients in their home or alternative facilities can be less than providing skilled nursing care in a nursing home and is an option that should be explored for providing long-term care to Minnesota veterans.[7]

10. The federal Veterans Administration has implemented community-based care models for aging veterans in the Medical Foster Home program. The program has homes within 35 miles of the Minneapolis VA campus, and each home provides for three adults with medical support provided by the VA. (See Appendix K)

11. The calculation of the maintenance charges, the amount billed to patients in the Minnesota veterans homes, do not have caps on all of the allowable deductions. Veterans pay a percentage of their income after allowable deductions are subtracted as a maintenance charge. Only a small percentage of the patients in the SVH pay the full cost-of-care rate because their income is too low. (See Appendix L)

12. The annual cost-of-care calculation for each SVH is calculated based on the average daily rate for the entire facility. The cost of care does not include all of the costs associated with operating the SVHs. The cost of care does not include capital expenditures greater than $30,000, MDVA Commissioner or Deputy Commissioner related costs, MDVA central office administration costs, agency-wide initiatives,

[7] See "Status of Long-Term Care in Minnesota 2010: A Report to the Minnesota Legislature" Continuing Care Administration, http://www.agingservicesmn.org/inc/data/PDF/Status_of_LTC_In_MN_8.15.10.pdf; See also Wendy Fox-Grage and Jenna Walls, "State Studies Find Home and Community-Based Services to Be Cost-Effective" AARP Public Policy Institute http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

information technology (IT) projects, and safety and construction administration costs.

13. Veterans home residents have a one year look back period regarding the divestment of assets, meaning that veterans can sell or gift their assets to anyone up until one year prior to entry into the state veterans home. Veterans can give assets to their spouse and children up until the day before they move into the home. Veterans using Medicaid to pay for care in the state's veterans homes will be subject to a five-year lookback period in the divestment of assets. (See Appendix L)

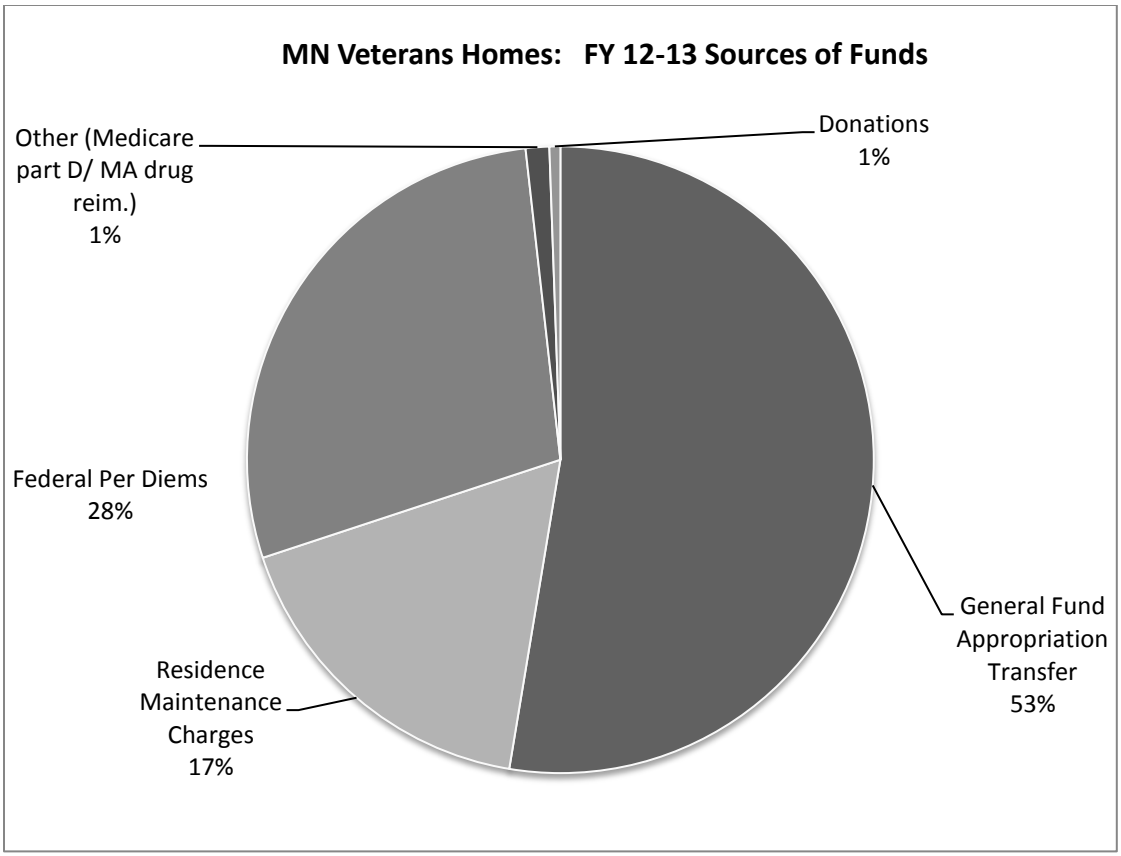
14. State veterans homes have a long waiting list for skilled nursing care, often requiring a wait of one year or more to be admitted. Each home maintains two waiting lists; one active list for applicants requesting immediate admission and the other a list indicating a desire to be admitted sometime in the future. Veterans and nonveteran spouses have equal access to admission and cannot be bumped once their application is approved and they are placed on the active waiting list. (See Appendix J)

15. In practice, female veterans and female nonveteran spouses who have priority on the active waiting list are delayed admission to a Minnesota SVH until such time as a female single room or female double room becomes available.

16. Currently seventeen states only allow veterans to reside in their state veterans homes. Five states have a priority for veterans but allow spouses or other eligible non-veterans to be admitted when space is available.[8] (See Appendix I)

17. Expenditures for the Veterans Health Care program for fiscal years 2012-13 were $161.5 million, or 77 percent, of the department's budget. This program provides skilled nursing care, special care units for treatment of dementia, and domiciliary care. The Veterans Health Care activities are funded through a state general fund appropriation, resident maintenance charges, U.S. Department of Veterans Affairs per diems, and donations. The general fund appropriation is transferred to an account in the special revenue fund, where it is combined with the revenues from the resident payments and federal per diems. Expenditures for the five state Veterans Homes are made from this special revenue account.

[8] The 2007 Minnesota Governor's Veterans Long-Term Care Advisory Commission Report indicates that the State Veterans Home Board had informed the commission that priority was given to veterans over non-veterans, veterans from sister facilities if they required a change in the level of care, and to veterans transferred from another veterans home.



MDVA: Veterans Homes Sources of Funds, FY 2012-13
(dollars in thousands)

Veterans Homes: FY 12-13 Sources		
General Fund Appropriation Transfer	88,732	52.6%
Residence Maintenance Charges	29,216	17.3%
Federal Per Diems	47,710	28.3%
Other (Medicare part D/ MA drug reimbursement)	2,050	1.2%
Donations	947	0.6%
	168,655	100.0%

18. The state receives a per diem from the federal VA for veterans who reside in the home. There is a base rate for domiciliary care, Adult Day Center, skilled nursing care, and then a higher rate for skilled nursing care for veterans with a 70% or higher VA disability rating that is adjusted by the VA based on geographic region. Spouses do not receive a per diem for care in the homes. VA per diems cover approximately

28% of the amount of the total cost of operating the state's veterans homes in 2012.[9] (See Appendix M)

19. The full cost of care, as calculated based on a daily average of the cost to run the facility, is higher for spouses because they are not entitled to federal VA per diem. They are almost universally female, have historically less personal income to be applied against their maintenance charges, and tend to live longer than the male veterans – thus holding for a longer period of time bed space that could be used by a veteran. In 2012 the state paid approximately $5.65 million for the care of 61 non veteran spouses. (See Appendix J)

20. As of June 2013, there were 13,024 veterans in Minnesota that had a 70% or higher disability rating, which is approximately 3.5% of the total veterans population in Minnesota.

21. It is projected that the cost of skilled nursing care in the state's veterans homes will increase at the annual rate of 9% for the foreseeable future.[10]

22. The state has a moratorium on corporate licensed adult foster home beds and on group residential housing beds. If veteran-exclusive facilities were to be sought, there would need to be a statutory exception in these areas if they were appropriate to assist the veterans community.

23. Based on an August 2013 monthly statistical report of the SVHs in Minnesota, there were 23 African American residents (3.15% of the total population of the homes), two Hispanic residents (less than .5% of the population of the homes), and seven Native American residents (less than .5% of the population of the homes).[11]

24. Due to numerous inspection violations at the state veterans homes, the Minnesota Governor's Veterans Long-Term Care Advisory Commission was created in 2006. The commission issued a report in November of 2007.[12] The commission provided recommendations to improve the governing structure of the state veterans homes, improve the quality of medical care, improve organizational systems and performances, and to move towards a modern vision of long-term care and provide the services needed by changing demographics and the next generation of veterans.

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[9] The revenue from federal per diems and veterans maintenance charges will vary from year to year depending on the mix of resident types in the homes, the level of disability of the veterans in skilled nursing care, and the income and assets of the veterans in the program.

[10] 2013 Genworth Cost of Care Survey, https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html.

[11] The 2007-2011 American Community Survey shows that 95.6% of the Minnesota veterans population identifies as white (Caucasian), 1.9% identify as African American, 0.9% identify as American Indian, 0.5% as Asian or Pacific Islander, and 1.1% as Latino or Hispanic.

[12] Minnesota Governor's Veterans Long-Term Care Advisory commission Report, November 2007, http://www.leg.state.mn.us/docs/2007/other/070698.pdf

25. The Minnesota Governor's Veterans Long-Term Care Advisory Commission identified staffing and human resources problems that were systemic in the Minneapolis State Veterans home and problematic throughout the state veterans homes system. The Minneapolis Home nursing union continues to identify problems between the management and the nursing staff that pose health risks to patients at the Minneapolis State Veterans Home.

RECOMMENDATIONS:

I. The Committee recommends that the state continue to fund programs that provide a continuum of housing and services to homeless veterans, including: emergency services, transitional housing, and long-term supportive housing.

   A. The state should support the expansion of scattered site transitional, domiciliary, and long-term local supportive housing for veterans. Programs that partner with the local communities and non-profits for services, building costs, maintenance, and daily operational costs of housing programs should receive state funding priority.

   B. MDVA, as a part of the Interagency Council on Homelessness, should remain involved in the council and the agency should focus support on employment services, transitional housing, and long-term supportive housing that will benefit Minnesota veterans.

   C. MDVA should develop new initiatives to end the disparity rate in homelessness for minority veterans by working with private and non-profit organizations to provide transitional, domiciliary, and long-term supportive housing, as well as employment training and on-going medical services.

II. The Committee recommends that all of the state's veterans homes that are eligible to become CMS certified apply to be certified no later than July 1, 2015.

III. The Committee recommends that the state veterans homes should focus on providing skilled nursing care to patients with the greatest medical need for skilled nursing care.

   A. Starting in August of 2015, admission to skilled nursing facilities in the state veterans home system should be based on medical and financial need and should incorporate the federal veterans designation of greater than 70% service-connected disability or the award of the Purple Heart as having the highest priority for entrance into the skilled nursing facilities. Second priority should go to all other eligible veterans. Only after those two priority lists have been exhausted, should nonveteran spouses be admitted. Priority should be given to veterans and spouses with a documented two-year residency in the state of Minnesota immediately prior to admission and to those veterans who lived in Minnesota at the time they entered the armed forces.

B. The homes should focus on decentralization of management and patient care to allow greater flexibility in nursing and patient care and to improve relationships and retention rates of employees, specifically nursing staff. The state veterans homes should immediately implement plans to improve employee retention rates and employee satisfaction in the workplace. MDVA should create an ombudsperson for the staff of the state veterans homes to work through employment disputes.

IV. The Committee recommends that the state pursue projects designed to allow veterans to "age in place" in local communities and to promote scattered site housing options for disabled and elderly veterans throughout the state.

A. The state should provide exemptions to the state moratorium for group residential housing and corporate adult foster care homes for veteran-exclusive programs. Programs such as the Eagle's Healing Nest in Sauk Center, should be available in partnership with MDVA, DHS, and the VA to provide quality care and greater access to locally operated programs for veterans.

B. The state should provide additional funding to scattered site housing for veterans needing assistance and housing due to disability, chemical dependency, mental health, and traumatic brain injury.

C. The state should provide grants and assistance to help veterans "age in place," including grants for assistive technology, respite, and in-home health care, group homes, and personal care services to allow veterans to remain in their homes and in their communities.

D. MDVA or the Department of Human Services should assist local agencies in developing a state-run pilot medical foster home project to provide veteran-exclusive housing for elderly veterans that promotes keeping veterans in their community and assists in keeping aging veterans out of nursing homes and in a home-like setting. Alternatively, these departments should encourage expansion of the VA medical foster home project in Minnesota through a partnership with the Regional VA Medical Center.

E. The Department of Human Services should investigate the potential for a veteran-specific waiver program to allow veterans disabled due to age or disability to have services in a group setting that is flexible to the needs and issues facing veterans.

F. MDVA should use the Minnesota 2013 Olmstead Plan[13] to improve services provided to disabled Minnesota veterans. The agency should implement the plan for those disabled veterans the agency serves.

G. MDVA should model services on the Department of Human Services Reform 2020 Plan to provide care for aging and disabled veterans to improve in-home care and reduce the need for larger, more costly institutions. Whenever possible, MDVA should utilize the services through the Department of Human Services Reform 2020 Plan that are available to eligible veterans. MDVA should consider the model proposed in the 2007 Governor's Veterans Long-Term Care Advisory Commission Report to make the homes a point of entry for a continuum of care that is available through MDVA, the Regional VA Medical Centers, community based services, adult day care, home services, respite, and local assisted living facilities.

V. The Committee recommends that the domiciliary facility in Hastings and the domiciliary beds in Minneapolis should focus on the rehabilitation of veterans so that whenever possible they can return to the community.

A. The domiciliary in Minneapolis and Hastings should focus on mental health services, chemical and alcohol dependency treatment, and job training.

B. Future expenditures for domiciliary care should focus on decentralization of the programs to allow more access to care throughout the state and should focus on locations with a large or growing concentration of veterans and VA community based outpatient clinic. Scattered site housing models should be implemented to provide domiciliary care in a more residential setting.

VI. The Committee recommends that the state veterans homes seek additional sources of funding and study potential alternatives to bring more efficiency to services and administrations while maintaining quality and access to care for veterans.

A. The rising cost of nursing home care is unsustainable and new approaches to maintain quality health care for veterans should be explored. A study of the states' veterans homes should be done to look at practices that would increase the quality of care to veterans and reduce the operating cost of the state's veterans homes. The study should examine how to increase the number of veterans being served, assist in improving the quality of the state's services to veterans, and improve the sustainability of the veterans home program.

B. To the extent permitted by federal law, all state veterans homes including domiciliary facilities should be CMS certified to increase options to bill Medicaid and Medicare for services.

[13] *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan*, November 1, 2013, Minnesota Olmstead Subcabinet, http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_180147.pdf

C. The calculation of the maintenance charge that constitutes private pay from veterans to the state veterans home should be reexamined to ensure transparency, fairness, and the ability of the state to provide care for an many veterans as possible.

D. Starting in August of 2015, MDVA's asset limit for veterans entering the state's veterans home should include a five-year look-back period for the transfer, sale, or gift of any assets to any third party that is not their spouse or child.

E. Starting in August of 2015, the cost of care calculations should include the total cost of running the state's veterans homes.

F. MDVA should encourage veterans participation in MN Sure and assist whenever possible in helping veterans to obtain health insurance and long-term care insurance.

VII. State statutes should be revised to clarify the role and responsibilities of the commissioner of MDVA and the state legislature's role in approving expenditures for construction, maintenance, and the expansion of programs for states' veterans homes. MDVA should not be able to commit the state to new projects or increases in MDVA expenditures without the approval of the legislative branch.

VIII. To the extent feasible, MDVA's eligibility and admissions policies and procedures regarding the Minnesota State Veterans Homes should be codified in state statute, rather than established by rule or administrative policy.

IX. MDVA should review the recommendations contained in the 2007 Minnesota Governor's Veterans Long-Term Care Advisory Commission Report and provide an explanation to the governor and the legislature as to which recommendations have been followed and which recommendations have not been followed.

Appendices

Appendix A: Minnesota State Veterans Home Admissions History, MDVA Veterans Home History, MN State Veterans Home Information Charts

Appendix B: Minneapolis VA Medical Health Care System Information

Appendix C: Update and Expansion for Overview of Housing Issues for Veterans Memorandum, dated November 21, 2013

Appendix D: Select Committee on Veterans Housing Minutes, October 1, 2013 and October 2, 2013

Appendix E: Radichel Townhomes Information Sheet

Appendix F: Department of Veterans Affairs Veterans Population Projections and Trends in Veterans with a Service-Connected Disability

Appendix G: HUD-VASH Chart

Appendix H: "Homeless Veterans in Minnesota: Statewide Survey of Veterans without Permanent Shelter" November, 2013 and "Homelessness in Minnesota" Findings from the 2012 statewide homeless study, Wilder Research[14]

Appendix I: Comparison of State Veterans Home Eligibility Chart

Appendix J: Minnesota Department of Veterans Affairs, PowerPoint Presentation to Select Committee on Veterans Housing, October 2013

Appendix K: VA Medical Foster Home Information Sheet

Appendix L: MDVA Financial Office, Frequently Asked Questions Guide and Expense Sheet

Appendix M: MDVA Financial Summary prepared by House Fiscal Staff, October 2013

Appendix N: Terms and Abbreviations

[14] Full reports available at: http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Homelessness%20in%20Minnesota%20-%20Findings%20from%20the%202012%20Statewide%20Homeless%20Study.pdf

http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Homeless%20Veterans%20in%20Minnesota%202012%20-%20Statewide%20Survey%20of%20Veterans%20Without%20Permanent%20Shelter.pdf.

APPENDIX A

Minnesota State Veterans Home Admissions History

Year	Admission Requirements	Notes
1905	Honorably discharged soldiers, sailors, and marines of the U.S. who served in the Mexican War, the War of the Rebellion, the Spanish-American War, and for persons who actually served in any campaign against the Indians in this state in the year 1962, whether as solider of the U.S. or not. *Residency Requirement:* One-year residency requirement, unless he served in a MN regiment or was credited to this state or served in an Indian campaign. *Income and Medical Requirement:* Must not have adequate means of support due to infirmity not be able to maintain himself.	
1927	Honorably discharged soldiers, sailors, and marines of the U.S. who served in the Mexican War, the War of the Rebellion, the Spanish-American War, the Boxer Rebellion, member of the MN National Guard used in federal service in 1916 in the Mexican Border War, or the war of 1917 and 1918 (World War I). *Residency Requirement:* One-year residency requirement, unless he served in a MN regiment or was credited to this state. *Income and Medical Requirement:* Unable to earn a living or maintain themselves due to wound, disease, or old age or infirmities.	In 1923 the law was changed to allow for entrance into the home when a veteran did have means of support, provided they entered into a contract to pay for the home.
1931	*Residency Requirement:* Added the requirement of a three-year residency in Minnesota unless he served in a Minnesota regiment, or was credited to the state, or served in the Indian campaign.	
1943	Added language to make eligible veterans gender neutral, and added the period of service of September 16, 1940, and December 7, 1941.	
1951	Added language to include the period of service for World War II, December 7, 1941, and December 31, 1946, and the campaign against North Koreans from June 25, 1950 on.	
1965		Changed the name of the home from "The Minnesota Soldiers Home" to the "Minnesota Veterans Home."
1967	Added the expiration for the North Korean Conflict and added the Vietnam Conflict.	

Year	Admission Requirements	Notes
1971	*Eligibility:* Veterans of all wars, and their wives, widows, mothers, and fathers who meet eligibility and admission requirements. Veterans who served during a period of war and were not dishonorably discharged. Defines period of war to include all previously noted periods, including the Civil War and Russian service during World War I. *Income and Medical Requirement:* Must be without adequate means of support and unable by reason of wounds, disease, old age, or infirmity to properly maintain themselves. *Special Requirements for Nonveterans*: Nonveterans have to be over 55 years of age and been residents of MN for five years, including widows that have lived in MN for 15 years who are eligible even if their spouse did not live in MN. Wives, widows, and mothers who was a MN resident for 10 years and left due to her own health or the health of the child or spouse can return to the state and be eligible. A wife or widow of certain foreign wars have to have been married to a spouse prior to specific years to be eligible.	Adds wives, widows, mothers, and fathers of wartime veterans. *Fathers only accepted if accompanying mothers. Allows the Board of Trustees of the Veterans Home to enact rules for governing the home including: admissions, maintenance, conduct, and discharge.
1973	Adds language to allow veterans who received bad conduct or dishonorable discharges from the armed forces of the U.S. as a result of drug dependency or abuse shall be eligible for admission to the home. (Removed from statute in 1988.)	Directs veterans services officers to assist veterans in securing counseling or treatment concerning alcohol and drug dependency and abuse.
1975	Changes the language for nonveterans to be gender neutral, to spouses, surviving spouses, and parents. Removes eligibility for active service against Indians, and provides ending service period for Vietnam conflict.	Removes language about veterans home board and replaces it with commissioner.
1984	Adds resident aliens who served in the armed forces as eligible for the veterans home.	Excluded work therapy income from income eligible for maintenance payments.
1988	Changed language from providing a home to a provider or "nursing care and related health and social services." *Removed eligibility* of parents *Removed the wartime requirement* and instead linked the definition of veteran to the definition used in Minn. Stat. § 197.447 (see 2013 current definition below). *Removes eligibility* for dishonorable discharge related to drug dependency and alien resident status.	

Year	Admission Requirements	Notes
1989	*Nonveteran eligibility:* Spouses and surviving dependents must meet all other requirements for eligibility into the home and be over age 55.	Creates a cost-of-care calculation, which can be charged to the patient, taking into consideration their income and assets.
2013	**198.01 VETERANS HOME; ELIGIBILITY OF VETERANS.** The Minnesota veterans homes shall provide nursing care and related health and social services for veterans and their spouses who meet eligibility and admission requirements of the Minnesota veterans homes. The word "veteran" as used in this section has the meaning provided in section 197.447. **198.022 ELIGIBILITY OF SPOUSES AND SURVIVING SPOUSES.** The commissioner is authorized to admit eligible spouses of those veterans who are, or if living would be, eligible for admission to the homes. (1) Except as provided in section 198.03, all applicants for admission to one of the Minnesota veterans homes must be without adequate means of support and unable by reason of wounds, disease, old age, or infirmity to properly maintain themselves. (2) Veterans must have served in a Minnesota regiment or have been credited to the state of Minnesota, or have been a resident of the state in accordance with rules adopted under this chapter preceding the date of application for admission. (3) Spouses and surviving spouses of eligible veterans must be at least 55 years of age, have been residents of the state of Minnesota in accordance with rules adopted under this chapter preceding the date of application for admission, and meet the criteria for admission to a home established in the rules of the home in accordance with this chapter and the applicable statutes and rules of the Department of Health.	

Prepared by Mary Mullen, House Research Department, November 2013

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History

1887
The history of Minnesota's Veterans Homes began shortly after the Civil War. Because of the devastation brought on by that conflict, there was a growing conviction that provisions should be made for the care of the nation's Veterans. The Minnesota legislature authorized the establishment of the Minnesota Soldiers' Home in 1887 as a "reward to the brave and deserving," and a Board of Trustees was established to manage the facility. By 1888 construction at the site of the current Minneapolis Veterans Home had begun; and by 1911 five men's cottages and one women's cottage had been built, along with several support services buildings (infirmary, dining hall, etc).

The mission of Soldiers' Homes, as they were contemplated in the last third of the nineteenth century, was to create beautiful, landscaped communities for Veterans - havens of rest for Veterans' later years. These homes were not primarily designed to be medical facilities. Rather, they were seen as monuments to the contributions of Veterans. In fact, it was not until World War I that medical care was provided in Soldiers' Homes, and even then it was of secondary consideration.

1930's
On November 11, 1934, construction of Building 9 on the Minneapolis campus was started. Completed in 1937, Building 9 was constructed almost entirely by hand over a span of nearly three years. The building was demolished in 2009 and was replaced with a 100 bed skilled care facility that was completed and dedicated in 2012. The time capsule from the original cornerstone, buried in November 1934, was opened in front of Residents, families, staff, state leaders and the media on July 7, 2009.

1960's
The view that Soldiers' Homes were rest homes persevered in Minnesota until the 1960s. In 1968, for example, the Minneapolis Soldiers' Home was licensed for 56 nursing care beds and 375 boarding care beds, the latter of which represented primarily custodial (non medical) care. By the late 1960s, however, the Soldiers' Home Board of Trustees, along with others, recognized a growing need for making the health care needs of Veterans a primary concern of the Home. The Soldiers' Home had been operated, since its creation, in a military atmosphere: the head of the facility was appointed as Commandant, and services and discipline were meted out in a quasi-military fashion. While the Board of Trustees began to recognize the growing health care needs of the Veteran population, and while there were increased efforts to provide medical and psychiatric care, the Home still had not made the conversion from rest haven to health care facility.

1970's
The 1970s were a time of change and growth for the Soldiers Home. In 1972 a new nursing care facility was constructed on the Minneapolis campus, and another was built by 1980. In 1978, the old state hospital in Hastings was converted into a domiciliary residence for Veterans. The Hastings State Hospital was opened in 1900 and closed on May 1, 1978. The Hastings Veterans Home opened on May 4, 1978.

As a result of the new construction in Minneapolis and the conversion of the Hastings facility, the Homes had 250 nursing care beds at Minneapolis, 250 domiciliary beds at Minneapolis and 200 domiciliary beds at Hastings. Along with this growth, the Board of Trustees was abolished, and the administration of the Soldiers' Home became a responsibility of the state Commissioner of Veterans Affairs in an effort to consolidate all matters pertaining to Veterans in one department.

1980's

In 1988, the legislature reorganized and separated the Veterans Homes from the Minnesota Department of Veterans Affairs. The Veterans Homes Board of Directors was established, consisting of nine members appointed by the governor. The Board was charged with restructuring the Homes along the lines of the medical model of operations and turning them into high quality health care facilities while also taking into consideration the special needs of the Veteran population. To accomplish this dual focus, the Board's membership consists of representatives from the health care field and Veterans organizations. The Board assures that the Homes are operated according to stated goals and standardized practices, policies and procedures, that Residents' rights are recognized and respected, and that a high quality of life is maintained for the Veterans who are Residents of the Homes. The agency itself was managed by an Executive Director, who was responsible for ensuring that the Board's vision for the agency, mission, and goals, are properly operationalized. Each Veterans Home is managed by an administrator, who at the time reported directly to the Executive Director. All of the facilities had medical directors, directors of nursing, and nursing, social services, financial and other staff appropriate to the needs and levels of care of their Veteran Residents.

1990's

Over the next 10 years three more facilities were added, bringing the number of Veterans Homes operating in Minnesota to five. The Homes were, and still are, located in Fergus Falls, Hastings, Luverne, Minneapolis and Silver Bay.

The Silver Bay Veterans Home opened on October 10, 1991. The facility for the Home began as Campton Elementary School and was built in 1953 during the mining boom on the North Shore. The school began a transformation to a Veterans Home in 1989. Governor Perpich delivered the grand opening address. Other dignitaries attending included; U.S. Senator Dave Durenberger, U.S. Senator Rudy Boschwitz, U.S. Representative Jim Oberstar, U.S. Representative Tim Penny and a number of state legislators. Fred Janklow was the first Administrator for the Silver Bay Veterans Home.

The Veterans Home in Luverne opened in 1994, and the Fergus Falls Home opened in 1998.

The breakdown of the beds was as follows: Minneapolis, 346 skilled nursing care beds and 77 domiciliary beds; Hastings, 200 domiciliary beds; Silver Bay, 89 skilled nursing care beds; Luverne, 85 skilled nursing care beds, and Fergus Falls, 85 skilled nursing care beds.

2007

On November 19, 2007, the Veterans Home Board was eliminated and the duties and responsibilities were transferred to the Minnesota Department of Veterans Affairs.

2009

Building 9 at the Minneapolis Veterans Home was scheduled for replacement in 2009. On July 7th, the original cornerstone from November 11, 1934 was opened and many artifacts were found inside the cornerstone. The new Building 9 consisting of a 100 bed skilled nursing care facility was completed in 2012. In an effort to preserve some of the historical elements from building 9, a number of original features and decor were incorporated and are displayed in the new building, including the cornerstone of building 9.

On July 29th, 2009 a ground breaking was held for a new 33,000 square foot addition at the Fergus Falls Veterans Home. The project was completed in 2011. The focus of the expansion was the special care unit featuring two state-of-the-art "community" or "village" concepts. The design for each of these areas is reminiscent of the look and feel of home, complete with a porch and window. The new special care unit also incorporated street lamps, park benches, a nursing station designed like a depot and enclosed outdoor wandering spaces.

2012

In 2012 the Adult Day Center and Building 19 were opened and dedicated. The Adult Day Center is the second in the country to offer day services in a Veteran-specific model of care operated by a state Veterans Affairs Department. This day program allows Participants maintain their highest level of independence and physical and mental well-being while remaining at home. The Adult Day concept also provides care and respite for caregivers, helping ease the strain of caring for a loved one or family member.

Building 19 is a state-of-the-art skilled nursing care facility that incorporates the latest technology and modern amenities to enhance care. This building has 100 private rooms designed around "neighborhoods" to offer care in a home-style atmosphere. This facility includes a greenhouse, barber and beauty shops, common areas with natural light and greenery and a town square.

Call 1-888-LinkVet (546-5838) for all Veteran-related questions. The information on this website is available in alternative formats; contact MDVA's Affirmative Action Office.

Minneapolis Veterans Home

Administrator	Established	Location
Dennis Decosta	1887	5101 Minnehaha Avenue S. Minneapolis, MN 55417

Capacity

Type of Bed	Licensed For	Currently Using
Skilled Nursing Beds	291	291[1]
Domiciliary Beds	50	45

Occupancy

Percent Occupied	Active Waiting List	Inactive Waiting List	Admission Wait Time
98%	717	472	9 Months (Domiciliary) 13 Months (Skilled Care) 15 Months (Special Care)

Staff

Total Employees	Total Full Time Equivalents
614	552.52 (including vacancies)

Services Offered

Individualized Care	Specialized Services	Programs	Special Features
• Skilled nursing care with a specialty in dementia care • Medical services, with 24-hour nursing care • Recreational therapy • Rehabilitation • Chaplain and spiritual care services • Diet and nutritional services • Pharmaceutical services • VA benefit assistance • Social services	• Barber and beautician services • Work therapy • Domiciliary care • Transportation to Minneapolis VA health care • Mental health services	• Resident council • Family council • Spouse support group • Community connections • Volunteer services	• Award-winning nursing care • Private and double rooms • Walking and biking distance to a variety of city parks and lakes • Mall of America, within 5 miles • VA Medical Center, within 1 mile • Metro Transit stops on campus • Walking distance to light rail

[1] The Minneapolis Veterans Home plans to add 100 additional beds pending state and federal funding.

Surveys

Date	Conducted By	Results
07/08/2013	Department of Veteran's Affairs	Pending
06/12/2013	Department of Health	Deficiencies – 6 skilled
	CMS Initial Certification	Pending
	DVA B16 Initial Certification DOMS	Pending
	Office of Legislative Auditor	Pending

Hastings Veterans Home

Administrator	Established	Address
Andrew Burnside	1978	1200 18th St. E. Hastings, MN 55053

Capacity

Type of Bed	Licensed For	Currently Using
Domiciliary	200	160

Occupancy

Percent Occupied	Active Waiting List	In Admissions Process	Admission Wait Time
96%	0	24	None

Services Offered

Individualized Care	Specialized Services	Programs	Special Features
• Nursing staff on site 24 hours a day to provide individualized care • Physicians and nurse practitioners on site • Medication management • Meal services and snacks • Social services support • Benefits assistance • Sheltered work opportunities • Therapeutic recreation • Mental health services • Transportation to medical appointments • Chaplain services • Pharmaceutical services • Benefits assistance	• Sobriety support • Sheltered work opportunities • Cashier/banking	• Resident council • Spouse support group • Community connections • Volunteer services	• Vocational rehabilitation

Staff

Total Employees	Total Full Time Equivalents
100	86

Surveys

Date	Conducted By	Results
01/08/2013	Department of Veteran's Affairs	Zero Deficiencies
08/2012	Department of Health	4 Deficiencies
03/31/2009	Office of the Legislative Auditor	14 Findings

Silver Bay Veterans Home

Administrator	Established	Address
Carol Gilbertson	1991	45 Banks Blvd. Silver Bay, MN 55614

Capacity

Type of Bed	Licensed For
Skilled Nursing	43
Special Care (Memory Loss)	40

Occupancy

Percent Occupied	Active Waiting List	Inactive Waiting List	Admission Wait Time
96%	94	93	6 Months

Services Offered

Individualized Care	Specialized Services	Programs	Special Features
• Skilled Nursing Care, including Dementia Care • Medical Service with 24-hour Nursing Care • Social Services • Recreational Services • Rehabilitation Services; Physical, Occupational and Speech Therapy • Rehabilitation Gym for Specialized Programming or Independent Activity • Mental/Behavioral Health • Chaplain and Spiritual Care Service • Nutritional Service • Pharmaceutical Service	• Transportation Service Locally and to Duluth • Barber and Beauty Services • Activities that Utilize our Natural Resources • Large Game Room • Craft Shop • Outdoor Activities	• Resident Council • Family Council • Spouse Support Group • Community Connections • Volunteer Services	• Pontoon Boat • Private Dining Areas • Four Season Porch • Garden

Staff

Total Employees	Total Full Time Equivalents
150	121

Surveys

Date	Conducted By…	Results
05/01/2012	Department of Veteran's Affairs	Zero Deficiencies
05/13/2013	Department of Health	6 Deficiencies

Luverne Veterans Home

Administrator	Established	Address
Luke Schryvers	1994	1300 N. Kniss Ave Luverne, MN 56156

Capacity

Type of Bed	Licensed For
Skilled Nursing	85

Occupancy

Percent Occupied	Active Waiting List	Inactive Waiting List	Admission Wait Time
99%	63	283	6-8 Months

Services Offered

Individualized Care	Specialized Services	Programs	Special Features
• Skilled Nursing Care, including specialized Dementia Care • Medical Service with 24-hour Nursing Care • Social Services • Individualized Recreational Services • Rehabilitation Services, including Physical, Occupational and Speech Therapy • Mental/Behavioral Health Service • Chaplain and Spiritual Care Service • Nutritional Service • Pharmaceutical Service	• Medical Transportation Service, Locally and to Sioux Falls • Barber and Beauty Service • Wireless Internet (in portions of the building) • Computer and gaming room • Small group activities	• Resident Council • Family Council • Spouse Support Group • Community Connections • Volunteer Services • "Adopt a Grandparent" Program	• Shopping Trips • Meals Out • Participation in local fair

Staff

Total Employees	Total Full Time Equivalents
171	111

Surveys

Date	Conducted By…	Results
08/09/2012	Department of Veteran's Affairs	1 Deficiency
08/29/2012	Department of Health	1 Deficiency
06/30/2001	Office of the Legislative Auditor	No Findings

Fergus Falls Veterans Home

Administrator	Established	Address
Jon Skillingstad	1998	1821 N. Park Street Fergus Falls, MN 56537

Capacity

Type of Bed	Licensed For
Skilled Nursing	85
Skilled Nursing (Special Care Unit Veteran's Village)	21

Occupancy

Percent Occupied	Active Waiting List	Inactive Waiting List	Admission Wait Time
96%	139	502	6-8 Months

Services Offered

Individualized Care	Specialized Services	Programs	Special Features
• Medical Services • 24-hour Focused Nursing Services • Pharmaceutical Services • Recreation Therapy Services • Chaplain Services • Dietetic & Nutritional Services • Rehabilitation Services • Assistance with VA Benefits • Social Services	• Barber Shop • Beauty Shop • General Store • Library • Family Inn • Cashier • Exercise Room • Transportation to Medical Appointments	• Resident Council • Family Council • Spouse Support Group • Community Connections • Outings • Volunteer Services	• Award-winning Nursing Care approaches • Private and semi-private rooms • Transportation to VA Medical Center • Main Street - a trip back in time • Interior open-air recreational area

Staff

Total Employees	Total Full Time Equivalents
187	121

Surveys

Date	Conducted By...	Results
10/02/2012	Department of Veteran's Affairs	Zero Deficiencies
05/13/2013	Department of Health	3 Citations
06/30/2007	Office of the Legislative Auditor	No Findings

Minneapolis Home Adult Day Center

Administrator	Established	Address
Jon Skillingstad	2013	5101 Minnehaha Avenue S Minneapolis, MN 55417

Capacity

Services Licensed For	Licensed to Serve
Adult Day Services	35

Services Offered

Individualized Care	Specialized Services
• Registered Nurses • Social Workers • Recreational Therapists • Program Assistants • Behavioral Health Specialists • Physical Therapists • Dietitian	• Bathing • Barber Shop and Beauty Parlor

Name	Established	Occupancy	Total Beds Licensed For	Active Waiting List	Wait Times	Total Full-Time Equivalent Employees
Minneapolis	1887	98%	341[1]	717	Domiciliary: 9 mo. Skilled Care: 13 mo. Special Care: 15 mo.	614
Hastings	1978	96%	200	0	None	86
Silver Bay	1991	96%	83	71	6 mo.	121
Luverne	1994	99%	85	63	6-8 mo.	111
Fergus Falls	1998	96%	106	139	6-8 mo.	121
Total (All Facilities)		96% (Weighted Average)	815	917		1053

[1] The Minneapolis Veterans Home plans to add 100 additional beds pending state and federal funding.

APPENDIX B

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Homeless Veterans

Community Resource and Referral Center (CRRC)

The Minneapolis VA operates one of 17 VA centers nationally, aimed at ending homelessness among Veterans.

Our mission is to support Veterans, who are experiencing homelessness or who are at risk of homelessness or serious mental illness, by promoting physical and mental health, assisting in securing and maintaining housing, and working with Veterans to achieve increased community integration.

Located in downtown Minneapolis - near the Basilica of St. Mary, MCTC, and the University of St. Thomas, the CRRC is one block southeast of Hennepin Avenue, and three blocks northwest of Nicollet Mall.

ADDRESS
1201 Harmon Place, Minneapolis, MN 55403

Additional VA Resources

If you are a Veteran who has lost your home, VA can help you get back on your feet. Contact VA's National Call Center for Homeless Veterans at 1-877-4AID-VET (1-877-424-3838) to speak to a trained VA responder. The hotline and online chat are free and neither VA registration nor enrollment in VA healthcare is required to use either service.

When you call or join the online chat:

- You will be connected to a trained VA responder.
- The responder will ask a few questions to assess your needs.
- If you're a Veteran, you may be connected with the Homeless Program point of contact at the nearest VA facility.
- Contact information will be requested so staff may follow up.

VA offers these services, all available via 1-877-4AID-VET, to homeless Veterans and Veterans at risk of homelessness and their families:

Opportunities to return to employment

VA's **Compensated Work Therapy (CWT)** is comprised of three unique programs which assist homeless Veterans in returning to competitive employment: Sheltered Workshop, Transitional Work, and Supported Employment. Veterans in CWT are paid at least the federal or state minimum wage, whichever is higher.

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CONTACT

Community Resource and Referral Center
1201 Harmon Place
Minneapolis, MN 55403
612-313-3240

RESOURCES

Minneapolis Community Resource and Referral Center

VA Homeless Program

VA Health Care for Homeless Veterans

GET HELP

The **Homeless Veteran Supported Employment Program (HVSEP)** provides vocational assistance, job development and placement, and ongoing supports to improve employment outcomes among homeless Veterans and Veterans at-risk of homelessness. Formerly homeless Veterans who have been trained as Vocational Rehabilitation Specialists (VRSs) provide these services.

Safe Housing

The **Homeless Providers Grant and Per Diem Program** provides grants and per diem payments (as funding is available) to help public and nonprofit organizations establish and operate supportive housing and service centers for homeless Veterans. Learn more about the Grant Per Diem Program

HUD-VA Supportive Housing (VASH) Program is a joint effort between the Department of Housing and Urban Development and VA. HUD allocated nearly 38,000 "Housing Choice" Section 8 vouchers across the country. These vouchers allow Veterans and their families to live in market rate rental units while VA provides case management services. A housing subsidy is paid to the landlord on behalf of the participating Veteran. The Veteran then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Learn more about the HUD-VASH Program.

The **Acquired Property Sales for Homeless Providers Program** makes all VA foreclosed properties available for sale to homeless provider organizations-at a 20 to 50 percent discount-to shelter homeless Veterans.

The **Supportive Services for Veteran Families (SSVF) Program** provides grants and technical assistance to community-based, nonprofit organizations to help Veterans and their families stay in their homes. Learn more about the SSVF program.

Health care

VA's Health Care for Homeless Veterans (HCHV) Program offers outreach, exams, treatment, referrals, and case management to Veterans who are homeless and dealing with mental health issues, including substance use. At more than 135 HCHV sites, trained, caring VA specialists provide tools and support necessary for Veterans to get their lives on a better track. Call VA's toll-free hotline or visit the Health Care for Homeless Veterans (HCHV) Program page.

VA's **Homeless Patient Aligned Care Teams (H-PACTs) Program** provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans that integrates clinical care with delivery of social services with enhanced access and community coordination. Implementation of this model is expected to address many of the health disparity and equity issues facing this population and result in reduced emergency department use and hospitalizations, improved chronic disease management, improved "housing readiness" with fewer Veterans returning to homelessness once housed. Homeless Patient Aligned Care Teams (H-PACTs) Program

VA's **Homeless Veterans Dental Program** provides dental treatment for eligible Veterans in a number of programs: Domiciliary Residential Rehabilitation Treatment, VA Grant and Per Diem, Compensated Work Therapy/Transitional Residence, Healthcare for Homeless Veterans (contract bed), and Community Residential Care. VA is working to expand dental care to all eligible Veterans within this program. Homeless Veterans Dental Program

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) brings together providers, advocates, and other concerned citizens to identify the needs of homeless Veterans and work to meet those needs through planning and cooperative action. This process has helped build thousands of relationships between VA and community agencies so that together they can better serve homeless Veterans. For more information on Project CHALENG, call VA's toll-free hotline or visit the Project CHALENG web page.

Mental health services

Veteran Justice Outreach provides eligible, justice-involved Veterans with timely access to VA's mental health and substance use services when clinically indicated, and other VA services and benefits as appropriate.

VA's Substance Use Disorder Treatment Enhancement Initiative provides substance use services in the community to aid homeless Veterans' recovery.

The Health Care for Re-Entry Veterans Program helps incarcerated Veterans successfully rejoin the community through supports including those addressing mental health and substance use problems.

The Readjustment Counseling Service's Vet Center Programs feature community-based locations and outreach activities that help to identify homeless Veterans and match homeless Veterans with necessary services.

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Extended Care and Rehabilitation

PM&R | Hospice | Palliative Care | Medical Foster Home | GRECC

The Extended Care and Rehabilitation (EC&R) Patient Service line provides specialized services to Veterans in need of rehabilitation or extended care services.

Physical Medicine and Rehabilitation

Physical Medicine and Rehabilitation (PM&R) offers interdisciplinary rehabilitation services to help individuals maximize their independence and quality of life after injury or illness. We deliver a wide variety of clinical services including specialized rehabilitation services for survivors of brain injury, stroke, and amputation.

MVAHCS PM&R is home to the VHA Polytrauma Rehabilitation Center (PRC) for the Upper Midwest, VISN 23's Polytrauma Network Site, and the VHA North Central Regional Amputation Center (RAC).

Extended Care Center

Extended Care Center (ECC) is a hospital-based transitional care unit. ECC maintains an average length of stay of 32 days. Most patients require extended rehabilitation and care following surgery and/or lengthy hospitalizations before returning to independent living.

Home and Community Care

Home and Community Care (HCC) consists of programs that manage care in veterans' homes and community settings.

- Home-based Primary Care, a VA-staffed home care program serving veterans with chronic health conditions
- Home Telehealth Care, which incorporates technology and equipment to enhance patient monitoring
- Adult Day Health Care, a VA-staffed program offering structured programming and caregiver respite
- Other programs are delivered by community partners, but the VA benefits are managed by the VA staff of HCC. These programs include Community Nursing Home Care, Community Adult day Health Care, Skilled and Unskilled Home Care, Home Hospice Care, and Home IV therapy.
- Medical Foster Home Program

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CONTACT INFO

Location

Minneapolis VA Health Care System

Contact Number(s)

612-725-2000
866-414-5058

Hours of Operation

M-F 8a.m.-4:30p.m.

Geriatric Research Education and Clinical Center

The Geriatric Research Education and Clinical Center (GRECC) integrates models of clinical care, education and research to further the care of geriatric patients with dementia. GRECC offers education to staff through the Veterans Integrated Service Network (VISN 23). The GRECC's Memory Loss Clinic is a key component in the continuum of care of patients with Alzheimer's disease. Research activities focus on the development, diagnosis, and treatment of Alzheimer's disease and other dementias.

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APPENDIX C

Research Department

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Minnesota House of Representatives

November 21, 2013

TO: Rep. Newton and the Speakers Select Committee on Veterans Housing

FROM: Mary Mullen, Legislative Analyst

RE: Update and Expansion for the Overview of Housing Issues for Veterans

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This memo is intended to provide background on veterans housing issues based on questions raised by Rep. Newton, the chair of the select committee.[1] The major issues related to veterans housing are homelessness (see page 3) and how to best provide long-term care for elderly veterans (see page 11). This memo contains updated information from the September 20, 2013, memo, that was distributed to the committee. The additional information corrects errors that were in the original memo, summarizes testimony that was presented at the committee hearings in October of 2013, and adds information researched after the committee hearings.

The issue of veterans housing has garnered a great deal of media attention over the last few years. In summary, the major issues are as follows:

- Nationally, homelessness for veterans is a high priority for the federal administration, and a five-year campaign to end veterans homelessness is underway.
- Nationally, the overall population of veterans is decreasing, but the number of women and minority veterans is increasing.
- In Minnesota, the percentage of homeless adults who are veterans is decreasing.
- Minnesota offers a variety of housing programs for veterans, including federal- and state-run programs, as well as programs run by nonprofits.
- The aging veteran population is in need of long-term care and many states, including Minnesota, have opened new veterans homes and updated existing homes to meet changing needs.

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[1] In establishing the committee, Speaker Paul Thissen said: "The Select Committee on Veterans Housing will examine housing issues facing Minnesota veterans, including veterans with long-term care needs and homeless veterans. The Select Committee will hold hearings over the interim and may tour Minnesota's veterans homes in order to recommend policies that assure safe, high-quality, cost-effective housing for veterans in our state. The committee will issue a report with their recommendations by February 1, 2014."

- Minnesota's five veterans homes are run by the Minnesota Department of Veterans Affairs (MDVA) and are currently accommodating over 790 individuals and are anticipated to have 890 beds after updates to the Minneapolis veterans home are completed.
- Minnesota may be nearing existing federal caps on beds eligible to receive a federal reimbursement for care in the state veterans home.

Note: This memo is not intended to reach any conclusions and is only to provide background information in areas that might be relevant to the committee. The listing of housing programs is not an exhaustive list but provides basic information on the main housing programs available in Minnesota and through federally funded veterans programs.

Veterans and Homelessness

President Obama's Federal Strategic Plan to End Homelessness by 2020 and the Plan to End Veterans Homelessness by 2015 have focused federal attention to the issue of homelessness. There is now a U.S. Interagency Council on Homelessness that is working on homelessness generally with a focus on veteran homelessness.

Many publications and studies have resulted from this increased attention.[2] A prominent Minnesota study done by Wilder Research every three years counting and collecting information on homeless Minnesotans, has focused on veterans in the last few years. The National Coalition for Homeless Veterans is a large national nonprofit that has received federal grants to organize information and services from the U.S. Department of Veterans Affairs (VA) to help state and local organizations working to assist homeless veterans. Other nonprofits have started in recent years as well, including the Iraq and Afghanistan Veterans of America organization. The Minnesota Interagency Council on Homelessness has been reinvigorated in 2013 with plans to write a proposal to end homelessness.[3]

The problem of veterans homelessness persists. The following is from the U.S. Interagency Council on Homelessness report, *Opening Doors*:

> In 2009, on a single night, there were 110,917 adults experiencing chronic homelessness in America; three-quarters are men with the average age approaching 50. Almost one-third are veterans and most, despite disabling conditions, are not enrolled in Medicaid or other insurance programs. The cost to individuals and society is high. The mortality rate for these men and women is four to nine times higher than for the general population. In a wide range of communities, the extraordinarily high costs associated with the use of public services by those experience chronic homelessness have been documented. Health care is a major expense due to frequent and avoidable emergency room visits, inpatient hospitalizations, sobering centers, and nursing homes.[4]

This quote highlights the issues surrounding chronic homelessness, which in Minnesota means someone who has been homeless for one year or longer or who has experienced four or more episodes of homelessness in the last three years, which differs from the federal definition, which also requires a physical or mental disability or chemical dependency problem.

Attention has also been given to the issue of veterans benefits. Homelessness and housing are a major focus, and thus, states have taken action to pass laws reducing or suspending property tax for veterans or disabled veterans to create homeownership benefits for veterans.

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[2] The federal program led to "Opening Doors," a federal strategic plan to prevent and end homelessness that was published in 2010. The National Housing Conference choose to have veterans housing issues as a focus for its 2012 conference, finding that veterans were facing many of the same challenges as other Americans with "foreclosures, burdensome housing costs, underwater mortgages, and homelessness."[2] The National Housing Conference produced a publication in May 2013 that focuses on the issues of veterans homelessness, "Veterans Permanent Supportive Housing: Policy and Practice."

[3] Established in Minnesota Statutes, section 462A.29, involves 13 Minnesota agencies.

[4] U.S. Interagency Council on Homelessness, *Opening Doors, Federal Strategic Plan to Prevent and End Homelessness: 2010*, "Chronic Homelessness".

The Veteran Population[5]

It is estimated that the population for veterans is decreasing and will continue to decrease over the next 30 years.[6] In a 2010 VA study, the number of veterans was estimated to be just over 23 million. The number of women and minority veterans is expected to increase, and the utilization of veterans services by veterans for health, education, and disability compensation is anticipated to increase from current rates, while the total number of veterans will decrease.

The Minnesota veteran population is slightly older than the national average, and the overall veterans population has decreased over the last decade.

U.S. Census data shows that approximately one-fourth of the state's veterans population lives in Hennepin and Ramsey counties. Approximately 60 percent are located in 14 counties near the metro area: Hennepin, Ramsey, Anoka, Dakota, Washington, Chisago, Sherburne, Wright, Carver, Scott, Goodhue, Olmstead, Stearns, and Blue Earth. These counties have larger populations, and thus, larger veterans populations generally.

The Minnesota demographer has a map that shows Minnesota population changes, with growth expected in the population of those over the age of 65 seeing the greatest increases, especially in the Twin Cities metro area. The Minnesota State Demographic Center has predicted demographic trends, the indications being that Minnesota population will increase at a rate of 13 percent and the largest growth areas being the Twin Cities metro and surrounding counties, St. Cloud, and the north-central region.[7] The population over 65 years of age is estimated to grow by 47 percent, as opposed to the population under 65, which will grow at a rate of 6.34 percent. The largest growth areas for those over 65 are in the metro area, with rural areas seeing a decline in the number of people over 65.

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[5] The U.S. Department of Housing and Urban Development (HUD), the U.S. Interagency Council on Homelessness, the Department of Veterans Affairs, and countless state veterans agencies and nonprofits, including the Wilder Foundation, have all contributed to the literature and studies on homelessness and veterans. The statistics can differ some depending on many different methodologies employed by the studies.

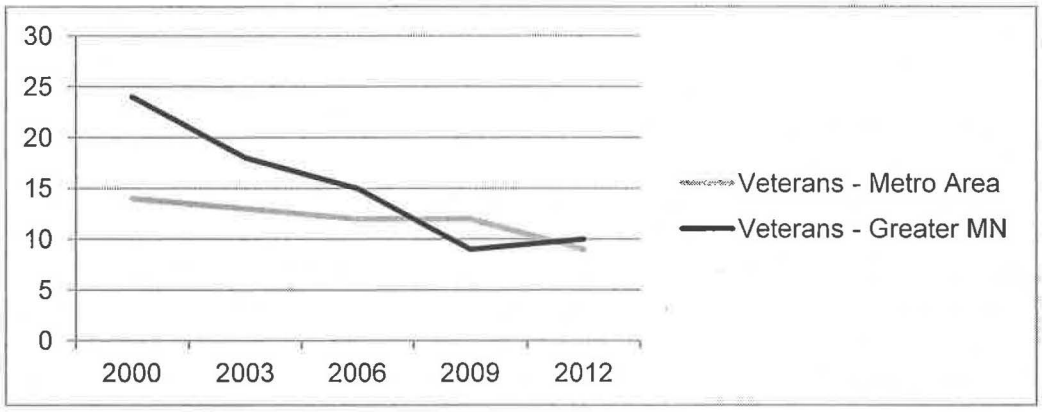
[6] The U.S. Census bureau has showed a small and steady decline in the number of veterans: in 1980 there were 28.5 million civilian veterans; in 1990 there were 27.45 million; in 2000 there were 26.39 million; and in 2010 there were just under 22 million. The largest number of these veterans in the 2000 census were Vietnam veterans, accounting for 31.7 percent of the total population; WWII veterans made up 22 percent of all veterans. In 2010, Vietnam veterans made up 35 percent of the total veterans population, and WWII veterans made up just under 10 percent of the total veterans population.

[7] Minnesota State Demographic Center, *Minnesota Population Projections: 2015 to 2040,* October 2012, http://www.demography.state.mn.us/PopulationPyramids2015-2040/Projecxtions2012Paper.pdf.

Veterans Homelessness and Recent Studies[8]

According to the National Coalition for Homeless Veterans (NCHV), 13 percent of the adult homeless population is veterans.[9]

The Minnesota Wilder Research study shows that overall veterans are becoming a smaller portion of the state's total homeless population since 2000. The graph below shows that the percentage of veterans in the homeless population in Minnesota has steadily decreased in both the metro area and in Greater Minnesota.[10]



The statistics on veteran homelessness shows improvements. The National Alliance to End Homelessness shows that veterans homelessness decreased 31 percent in Minnesota from 2011 to 2012 and decreased nationwide from 2010 to 2012.[11] Researchers speculate that the Minnesota reduction in homelessness for veterans is exaggerated due to the way in which homelessness statistics are gathered and measured; see footnote 11.

[8] Wilder, at 10. http://www.wilder.org/Wilder-Research/Publications/Pages/results-Homelessness-Housing.aspx

[9] National Coalition for Homeless Veterans, Frequently Asked Questions, available at (last visited May 20, 2013). A veteran is defined as a person that served in the active military, naval or air service and was not dishonorably discharged. See Libby Perl, Specialist in Housing Policy, Congressional Research Service, Veterans and Homelessness, 2-3 (February 4, 2013).

[10] Wilder Research, 2012 Homelessness Fact Sheet "Initial Findings: Characteristics and Trends" (April 2013) http://www.wilder.org/Wilder-Research/Publications/Pages/results-Homelessness-Housing.aspx.

[11] This statistics is based on the one-day headcount in shelters that is done annually in January. It is possible that this statistic is not an accurate count in Minnesota, where nearly everyone is indoors somewhere in January so the count of those who are "doubled up," staying with family and friends, and finding shelter outside of where they could be counted is very likely.

The Wilder Research study made the following conclusions about homeless veterans in Minnesota from the 2009 report:[12]

- 95 percent of homeless veterans completed high school and most attended at least some college (51 percent)
- 18 percent of homeless veterans are employed, and 82 percent are unemployed
- The main barrier to employment for those not working was physical health (32 percent)
- The main source of income was General Assistance
- 63 percent qualified as long-term homeless
- 57 percent went without housing for more than a year
- 35 percent are waiting on housing supplied through a voucher program

Mental and Physical Health of Homeless Veterans[13]

Veterans, like many homeless adults, often struggle with mental health issues and physical disabilities. A recent article that looks at VA data on the number of veterans suffering with chronic pain showed that there was a 133 percent increase since 2003 in reports of chronic pain, with over 100 percent increases in back and neck pain.[14] The 2009 Wilder study indicates that homeless veterans generally report having experienced a slightly higher rate of physical and sexual abuse as a child. Nearly half or more than half of the homeless veterans surveyed reported health problems, mental health problems, or chemical dependency problems. Mental health issues continue to be a persistent problem for homeless adults, and the Iraq and Afghanistan veterans are in need of assistance as much or more than other generations of veterans.[15]

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[12] Wilder Research, *Homeless Veterans in Minnesota 2009* (December 2010) http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota,%202009%20Study/Homeless%20Veterans%20in%20Minnesota%202009,%20Full%20Report.pdf.

[13] *Id.* at 11-13.

[14] Jessica Mador, *Chronic Pain Increasingly Accompanies Minnesota Veterans Home From War*, Minnesota Public Radio News, May 20, 2013.

[15] The Iraq and Afghanistan Veterans of America (IAVA) organization did a survey of members and found that that mental health and suicide is an urgent issue among the homeless veterans population; 37 percent of IAVA members that participated in the survey reported that they knew people that have committed suicide; 63 percent knew a fellow veteran with mental health issues; and 51 percent reported seeking treatment for mental health issues for themselves.

Veterans Housing Programs

Emergency shelters, transitional housing, temporary housing, and long-term housing (including public housing) have all emerged as a continuum of options to try to address homelessness, as shown in the table below. The modern focus is to prevent homelessness, provide outreach to connect people with services, provide shelter, and then move people to housing options that are most appropriate for their circumstances including: transitional housing, long-term supportive housing, rental assistance housing, affordable rental units, or homeownership.[16]

Program	Services	Operations
Health Care for Homeless Veterans	Mental health services, treatment, no housing	VA
Domiciliary Care	Housing for chemically dependent, mentally and physically disabled veterans	VA medical centers 2,233 beds nationwide
Grant Per Diem Program	Transitional housing for homeless veterans with grants to provide services; some construction costs available and per diems for each bed	VA 12,378 beds available **$41.90 per day per diem**
HUD-Veterans Affairs Supportive Housing (VASH)	Tenant-based housing vouchers to individuals with the VA providing supportive services; also project-based housing voucher program	VA and HUD
Demonstration Project	Assist veterans to find employment to end/prevent homelessness	Department of Labor Available in five states
Supportive Services Grants	Grants to organizations to provide supportive services to assist homeless veterans	VA Competitive grant program
Enhanced Use Leases	Use of VA property at low/no cost to assist in housing homeless veterans; use of foreclosed VA mortgaged homes to nonprofits or state agencies	VA

[16] The listed programs are veteran-specific housing programs. There is also a range of public housing and homelessness initiatives that service veterans along with the general population.

Minnesota Veterans Housing

Minnesota offers a variety of housing programs for veterans. These include the following federal, state, and nonprofit programs.

HUD-VASH

The Housing and Urban Development (HUD) Veterans Affairs Supportive Housing (VASH) program is operated by the VA and HUD to provide tenant-based housing vouchers to individuals, with the VA providing supportive services. While the program has been around since the early 1990s, the small number of set-aside vouchers was minimal compared to the need. In 2008, the program was revitalized when a $75 million appropriation was given to fund vouchers for homeless veterans. Since then the funding has continued and the voucher program has grown. The vouchers are distributed by the local public housing authorities (PHA). HUD and the VA determine which areas get vouchers based on PHA performance, demographics, and other specifications.[17] HUD-VASH vouchers can also be "project based" which means that the PHA can use the vouchers for a housing project or building and the voucher stays with the project instead of with the tenant. These projects are popular way to provide supportive housing because the individuals are not at scattered sites, and useful in areas where it is hard to find private landlords who will accept housing vouchers.[18] Statistics have shown that veterans that use HUD-VASH programs, as opposed to other housing programs, showed lower levels of homelessness and substance use and less frequency in institutions.[19]

As of May 2013, the program had provided 48,385 vouchers. This is considered the cornerstone of the 2015 federal goal to end veterans' homelessness. The voucher is used similar to a Section 8 voucher; it travels with the individual so they can rent privately owned housing and the tenant usually pays no more than 30 percent of their income. The attached chart shows the number and location of HUD-VASH vouchers in Minnesota.

MACV

Minnesota Assistance Council for Veterans (MACV) is a private nonprofit organization that provides services to Minnesota veterans who are homeless or in crisis and at risk of homelessness. MACV provides emergency assistance such as rent, mortgage, and utility assistance, as well as housing, employment, and civil legal assistance. MACV has three main outreach offices, in Mankato, Duluth, and the Twin Cities, as well as satellite offices in Little Falls and Detroit Lakes. Veterans throughout the state can access services through these offices, or remotely through their county veterans' services offices. MACV provides 55 beds in 13 transitional homes for veterans (11 in the Twin Cities including a home for female veterans; one in St. Cloud and two in Duluth), 22 units of permanent housing with 11 units in Mankato and 11 units in Duluth, for a total of 77 beds. MACV's focus is on serving homeless and in-crisis veterans. MACV serves honorably discharged veterans of all ages and from all eras. Some programs have income and Minnesota residency qualifications. Some of the program's beds are

[17] Perl, 28.

[18] Perl, 29.

[19] Perl, 30.

set aside for disabled or the chronically homeless veterans. All MACV-operated housing is supported by case management services and is chemical free. The total operating budget for MACV in 2012 was $4,153,740. This is raised through private donations, fund-raising, federal and state grants, and program fees for some housing residents.

Al Loehr Veterans and Community Studio Apartments and Minneapolis Veterans Community Housing

Housing programs were developed in St. Cloud and Minneapolis and built with general obligation bonds in the early 2000s. The Al Loehr Veterans and Community Studio Apartments in St. Cloud are for single adults who are homeless, and can house 60 people on the VA medical campus. The apartments are owned by St. Cloud Housing Redevelopment Administration on the grounds of the St. Cloud Veterans Administration Medical Center; the land is owned by the VA. The building is wheelchair accessible, seven units are designed for disabled veterans, and the building is chemical free. To be eligible a person must be single, homeless or in danger of becoming homeless, must have an income, and must be drug and alcohol free. The rent is set at $383 per month. The average annual income of individuals staying there is $14,470.[20]

The Veterans and Community Housing in Minneapolis opened around 2006, and the 140-unit apartment complex has a more than a 51 percent veteran occupancy rate and is drug and alcohol free. It was built by the Community Housing Development Corporation. It is owned by the Hennepin County Housing and Redevelopment Authority and located on land owed by the VA. It requires that residents be single adults, drug and alcohol free, and homeless or in danger of becoming homeless. The rents were originally set at $385 per month. The average annual income in 2012 was $17,383.[21]

Common Bond Project for Minneapolis and St. Cloud

Last year the Minnesota Housing Finance Agency (MHFA) funded two veterans housing projects using proceeds from housing infrastructure bonds. One of the projects is in St. Cloud, on land leased from the VA, and the other is at Fort Snelling in Minneapolis. The housing is intended to provide permanent supportive housing for homeless veterans and is being developed by Common Bond, a non-profit low-income housing developer. In addition, Common Bond is planning to develop efficiency, one-bedroom, two-bedroom, and three-bedroom (Minneapolis only) apartments in these two sites and has already received the MHFA infrastructure housing bonds, MHFA Challenge Funds, tax credit equity, VA funding, and a grant from the Home Depot Foundation to help fund the program. Common Bond is hoping to get HUD-VASH project-based vouchers, which would be the first HUD-VASH project in the state of Minnesota.

[20] In 2012, 60 residents received rental assistance, 27 received supportive services, 16 received Social Security, 17 received unemployment, and two received retirement benefits.

[21] 77 of the residents were on Social Security, 28 received retirement benefits, and four received unemployment benefits.

CommonBond VA Fort Snelling (Minneapolis)

- 58 units, majority for single adults and eight units for households with children
- Income limits are 30 percent to 60 percent of area median income

CommonBond VA St. Cloud

- 35 units total including 33 for single adults and two for families with children
- Income limits are 30 percent to 60 percent of area median income

The Eagles Healing Nest is a non-profit organization operating a housing facility for veterans in Sauk Centre. It has a board and care license from the state and offers supportive services including access to mental health professionals, chemical dependency, and alternative therapies to residents staying in the facility. The facility charges $35 per day to its residents which covers food, lodging, and services. The Eagles Healing Nest currently houses 15 veterans but has a capacity for 35 veterans. It does not currently receive either state or federal grant funding.

Minnesota Housing Finance Agency Programs Serving Veterans

The Family Homeless Prevention and Assistance Program last year served 428 veterans, which is about 5.5 percent of the total number of households served by the program. Last year 211 long-term homeless veterans were served with Long-term Homeless (LTH) funds from the agency's Housing Trust Fund—this is 6.33 percent of all households served with LTH funding.

At least 1 percent of MHFA first-time homebuyer loans are VA insured, meaning they were given to veteran households. About 50 percent of the loans are FHA insured, and likely include loans to veterans.

Supportive Services

Supportive services are an important part of many of these housing programs and can include: health care, psychiatric care, daily living services, personal finance planning services, transportation, legal assistance, child care services, and housing and employment counseling.

For the HUD-VASH program, the VA medical program provides supportive services. Supportive services can also be provided for by federal and state grants through nonprofits and are an integral part of most housing programs aimed at ending homelessness. Lutheran Social Services currently has a program for veterans to help veterans and their families gain mental health and financial counseling services. The Case Management, Outreach, Referral and Education (C.O.R.E) program is free to active duty military and is provided through Lutheran Social Services and the Minnesota Department of Veterans Affairs.

Long-term Care Options for Veterans

Veterans Administration Care Options

The Minneapolis VA hospital provides nursing home care through its community living center located at the VA Medical Center. The VA Medical Center also contracts with private nursing homes and can provide payments for those veterans who are considered 70 percent disabled. There are specific criteria for the disabled veterans and the facility must meet all the federal guidelines and requirements to be eligible for that funding. Currently there are 60 community nursing homes contracted with the VA in Minneapolis to provide these services. The VA hospital also provides rehabilitation and hospice to eligible patients.

The VA also operates a new program called Medical Foster Homes. These homes provide long-term skilled nursing care in a residential setting and involve case management by a VA home care team including nurses, social workers, psychologists, and occupational therapists. They are private pay, with the average rates between $1,800 to $4,000 per month, and they can take long-term care insurance. The programs also can get VA regional office funding and county/state funding. It is unclear how much VA funding assists the clients with the cost or if that only covers the VA medical center care and transportation.

State Veterans Homes

State-run veterans homes have also received additional funding at the state and federal level since the late 1980s as the Vietnam veteran population has had more of a long-term care need, and since then many states have replaced veterans homes or built new veterans homes. Many of the updates come on the heels of a changing culture in health care and housing, moving away from "institutionalizing" patients. The new designs tend to embrace a more residential feel and provide more privacy and dignity than the previous models.

In just the past two years new homes have opened in numerous states including Texas, California, Arizona, Alaska, North Carolina, Utah, and Wisconsin. Other states are updating homes, including Iowa, Maine, Delaware, Maryland, Pennsylvania, and Minnesota. New homes are being built to replace outdated homes in Arkansas, North Dakota, and South Dakota. Many of these homes are being built with 65 percent of the cost provided by the VA and the other 35 percent coming from state funding.[22] This boom in veterans home building has created a lot of discussion about the need for the facilities and the ability to continue to fund the homes over time.

State-run veterans homes are built using state money or a combination of state and federal VA money. The federal VA accepts applications from state agencies for the construction of a new veterans home. The state submits an application and once the legislature and the governor have signed off on the law to create and fund a new veterans home, the VA will consider the application. The state owns the veterans home, and the VA provides a per diem rate for specific

[22] The cost to run the homes comes from many different sources and includes state funds, private individual payments from the residents, and Medicaid when it is available and the home is eligible.

services to the veterans home including skilled nursing (nursing home care), domiciliary (assisted living), and adult day care services.

Statistics on the National State Veterans Home Program, 2012[23]

- 142 state veterans home facilities
- 133 nursing home care programs with 24,505 beds
- 54 domiciliary care programs with 5,872 beds
- 2 adult day health care program; New York has a license for 50 participants and Minnesota has a license for 35 participants

The VA has very specific requirements for veterans homes, similar to nursing homes and hospitals, and those safety requirements are often very costly to construct. For example, veterans homes need wide hallways and doorways for wheelchairs, sprinkler systems, fire-proof doors, and certified safety and medical equipment. The VA also has preference in funding the building of veterans homes. For example, new homes are preferred to renovation of old homes and a person-centered care model focused on "neighborhood" models is preferred over an older hospital or institutional setting.

Veterans homes were first built after the Civil War, and many states created veterans homes in the 1880s and 1890s. Many of the old homes have been renovated due to new safety standards or entirely new homes have been constructed. North Dakota and South Dakota are examples of states that are building new homes as the previous homes were outdated. Some states have begun to build multiple veterans homes spaced out throughout the state to accommodate veterans in different areas.

Texas is an example of the new model for building veterans homes, as it has built a number of new homes over the last decade (see attached Comparison of State's Veterans Home chart). The Texas Confederates Home was build in the 1880s for aging Civil War veterans and later housed WWI and WWII veterans but was shut down in 1963. For years, Texas had no state veterans home, and in 1997 the state appropriations were passed, and with the help of the VA, Texas built four new veterans homes. Texas now has eight veterans homes. The homes are mostly one-story facilities, with a focus on privacy; each home houses between 100 and 160 individuals. In contrast, Illinois has a few smaller veterans homes built in the 1990s, which house as few as 15 veterans but in some cases over 100, as well as an original veterans home built in 1886, which has over 400 beds.

The trend towards having more than one veterans home appears to have started in the late 1980s and early 1990s as a general trend in care for the disabled and elderly moved away from institutional settings. Many states still only have one veterans home, and this is especially true of states with small populations, such as neighboring North Dakota, South Dakota, and Iowa. North Dakota and South Dakota are both in the process of building new veterans homes, on or near the site of their existing home with the help of VA funding to update what were considered

[23] Kelly Schneider, U.S. Department of Veterans Affairs, "State Home Per Diem Program" *National Association of State Veterans Home Conference,* July 10, 2012.

outdated and unsafe facilities. The VA reimbursement (per diem) for individuals staying in the veterans home in South Dakota was at risk of being cut because the facility did not meet the federal requirements.

Wisconsin is another example of the recent trend to build new veterans homes on different campuses throughout the state. The original veterans home in King, Wisconsin, is well over 100 years old, still has over 700 beds, and operates as an assisted living facility. A new facility was built in Union Grove, Wisconsin, seven years ago and has 158 nursing home beds and 40 assisted living beds. Additionally, a brand new facility opened last year in Chippewa Falls that has 72 beds. The newest facility indicates it has "neighborhoods" with more household-style residence.

In recent years large states with large veteran populations have struggled to cover the operating costs of the veterans homes. California has 1.9 million veterans, which is 8.3 percent of the total U.S. veterans population. Currently there are six homes there, with two additional smaller homes anticipated. The state has nearly 3,000 beds available in these homes but can only afford to operate with 2,000 beds due to the budget, staff, and federal approval required for the facilities.[24] Because of the contract the state signed with the VA when the homes were built, the state is obligated to fill the beds, keep occupancy rates high, and run the home as required by the contact for a certain number of years.

Minnesota Veterans Homes

Minnesota currently has five veterans homes. Similar to other states, Minnesota has an original veterans home that was build in the 1880s and still exists today along with newer buildings surrounding it. This is the Minneapolis Veterans Home that currently has 291 nursing home beds and 50 assisted living (domiciliary) beds.[25] This home is anticipating renovations that will add 100 beds and then the Minneapolis home will have a total of 441 beds. In 1974, the state closed the Hastings state hospital and turned that facility into a veterans domiciliary. Opened in Hastings in 1978, it was licensed for 200 assisted living beds and is now licensed for 180 beds. This domiciliary facility, as well as the 50 beds in the Minneapolis home, do not have age restrictions and thus offer rehabilitation and permanent housing to veterans who may be suffering with disabilities, mental illness, and chemical dependency issues that are barriers to finding other suitable housing.

Similar to other states, Minnesota built three more veterans homes in the 1990s in Fergus Falls (106 beds previously, currently 101), Luverne (85 beds), and Silver Bay (83 beds). This is like the general move towards smaller, more residential models for veterans homes that has emerged over the last 20 years. Some of these homes also have dementia units, including the Minneapolis home, allowing a certain number of beds for dementia patients. The VA-authorized state cap[26]

[24]Michael Gardner, "State Grappling with Costs of Veterans Homes," *The San Diego Union-Tribune*, May 6, 2013, http://www.utsandiego.com/news/2013/may/06/california-grappling-with-costs-of-veterans-homes/all/?print.

[25] The facility is licensed for 161 domiciliary beds and 341 nursing home beds according to the state Department of Health nursing home license for the facility.

[26] The state can formally request an increase of allowable beds based on 38 CFR 59.40 :

for veterans home beds is 1,058, and currently the VA shows that Minnesota has 859[27] authorized beds and 201 are planned or under construction. The difference between the federal Veterans Administration (VA) bed count and the Minnesota Department of Veterans Affairs (MDVA) bed count for the five Minnesota state veterans homes includes inaccurate counting by the federal VA of homes in Wisconsin and not in Minnesota. MDVA has indicated that there are currently 790 operating beds in the Minnesota state veterans homes. MDVA has stated that the operating beds are the beds that count towards the VA's total state bed count which are eligible for per diem reimbursement. The Minneapolis home is anticipated to complete Phase 2 and Phase 3 of their construction which will increase the size of the home by 100 beds, bringing the total number of beds for that home to 441 beds. MDVA has indicated that adult day slots do not count toward the total bed count for the maximum allowed bed to receive per diems from the VA.

The most recent changes for Minnesota veterans homes has been the renovations at the Minneapolis Veterans Home in recent years. Here is an excerpt from the Minneapolis Veterans Home website describing the updates:

> In 2012 the Adult Day Center and Building 19 [rebuilt former residential unit of the original veterans home] were opened and dedicated. The Adult Day Center is the second in the country to offer day services in a Veteran-specific model of care operated by a state Veterans Affairs Department. This day program allows Participants to maintain their highest level of independence and physical and mental well-being while remaining at home. The Adult Day concept also provides care and respite for caregivers, helping ease the strain of caring for a loved one or family member.
>
> Building 19 is a state-of-the-art skilled nursing care facility that incorporates the latest technology and modern amenities to enhance care. This building has 100 private rooms designed around "neighborhoods" to offer care in a home-style atmosphere. This facility includes a greenhouse, barber and beauty shops, common areas with natural light and greenery and a town square.

The Minnesota veterans homes are operated by the state with funding assistance through federal VA per diems for each patient, which can cover up to 50 percent of the cost of care. The VA has provided up to 65 percent of the funding for the renovation and new construction of veterans homes in recent years through a competitive application process. In the 2013 legislative session, the Minnesota Legislature passed $18 million in general obligation bond funds that are to go to finish part of the renovations and building projects. The MDVA will learn between August 1, 2013, and October 1, 2013, whether or not it is awarded the VA funding to complete the project. The VA could choose to award the full 65 percent or a lesser amount, depending on the available

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> (b) A State may request a grant for a project that would increase the total number of State nursing home and domiciliary beds beyond the maximum number for that State, if the State submits to VA, documentation to establish a need for the exception based on travel distances of at least two hours (by land transportation or any other usual mode of transportation if land transportation is not available) between a veteran population center sufficient for the establishment of a State home and any existing State home. The determination regarding a request for an exception will be made by the Secretary.

[27] The total beds licensed indicated by the facilities is 790; the VA indicates that there are 859 licensed beds and the Minnesota nursing home license indicates there are unused licensed beds in the Minneapolis home.

funds. The final phase that is to be completed is to provide much of the supportive areas and underground tunnels as well as additional beds.

MDVA conducted a study in 2009 to determine criteria for the site selection of a future Minnesota veterans home with optimal benefits for veterans and the state of Minnesota, using federal requirements on the separation between veterans homes necessary to receive federal funding and demographics that show a current and future need from veterans. The study found 27 communities met the federal requirements, and 17 of those 27 met the demographic, workforce capability, and medical capabilities to support a veterans home.[28]

MDVA informed the committee at the October 2, 2013, committee hearing that the applications for federal match funding for construction of new veterans homes in Willmar, Montevideo, Brainerd, and Bemidji had been withdrawn. MDVA indicates that shortly after April 4, 2013, they were contacted by the federal VA and told that the applications for the state veterans homes that had been previously submitted were beyond the total state bed count allowed under federal law. The federal law caps the Minnesota state veterans home beds at 1058. This cap is seen as the total need for beds, so beds waiting in the line are included in the total as potentially fulfilling the need.

The Minneapolis home is remodeling one building which has 100 beds and building a new building which has 100 beds, meaning that application had 200 beds total in the line for funding, even though the net gain is only 100 beds. The previously submitted home requests included: Willmar (90), Montevideo (90), Brainerd (70), and Bemidji (70). The VA indicated that the total operating bed count, which MDVA indicates is currently 790, plus the 200 pending beds for the Minneapolis Veterans Home, brought the total to 990. None of the requests could fit with the remaining 68 beds, so all of the other applications were pulled. The federal VA also indicated that the Willmar proposal was probably not going to work because it involved a land lease, which is against the state's veterans home policies. Further, Montevideo was very close to being two hours away from the Fergus Falls state veterans home which could prevent it from being funded according to MDVA. Finally, the Brainerd and Bemidji homes are within two hours of each other and thus only one of those homes could proceed.[29] Additionally, the bed caps are reviewed by the VA every four years and could potentially increase in future years or the state can request an increase under certain circumstances.[30]

MDVA indicates that once the Minneapolis home is completed, the total bed count for the state will be at 890, leaving 168 beds available. MDVA also indicated that the applications can be resubmitted to the VA at anytime and the previously passed legislation authorizing these applications is still valid. However, some of the information they presented in the committee hearing also indicated that there may be problems with some or all of the homes proposed and that those issues should be resolved before further funding is sought.

---

[28] Aitkin, Bagley, Bemidji, Blue Earth, Brainerd, Crosby, Deer River, Grand Rapids, Hibbing, Little Falls, Montevideo, Moose Lake, New Ulm, Olivia, Paynesville, Virginia, and Willmar.

[29] The two hour proximity seems related to INCREASING the bed count over the state allowance, but it does not necessarily apply when the state is under the total allowed amount.

[30] The cap was previously 982 and was increased in 2010 so it is likely the cap will be reviewed again in 2014. However, the cap is based on the veterans population so without an increase in the state's veterans population it is unlikely the cap will increase.

Funding for State Veterans Homes and the Cost of Long-Term Care

Unlike in private nursing homes, which often receive half or more of their funding from state and federal Medicaid and Medicare funds, the veterans homes use a federal per diem to assist with the cost of care.[31] The MDVA could qualify for Medicaid and Medicare funds with renovations to the Minneapolis home to assist with the operation costs.[32]

Currently the state home receives some VA payments and the rest is paid for by the individual, long-term care insurance, and state funding. This keeps costs low for the veterans using the home. Below is the current federal per diem for state veterans homes. The highest rate per diem for veterans who are 70 percent or more disabled by the VA rating system have all of their care covered by the per diem. The average number of veterans in the Minnesota state homes receiving this per diem was 42 in fiscal year 2012, which is approximately 3 to 4 percent of the total population in the state veterans homes.

The FY 2013 Basic State Home Per Diem Rates:*

Adult Day Health Care	$77.22 per day
Domiciliary	$41.90 per day
Nursing Home	$97.07 per veteran, per day**
Per diem for selected veterans under P.L. 112-154[33]	Luverne: $362.23 Silver Bay: $362.23 Fergus Falls: $362.23 Minneapolis: $424.41
*38 C.F.R. 17.197 provides that the rate cannot exceed more than one-half of the actual costs of the veteran's care in the state home. **Severely disabled veterans have a much higher per diem rate see below	

[31] The average cost of a nursing home in Minnesota for 2013 is approximately $6,007.33 a month for a semi-private room and $6,661.25 for a private room. The average cost of an assisted living facility for a private, one-bedroom is $3,350 per month. An adult day health care program is around $1,430 per month.

[32] Medicaid pays for nursing home care and medical care for individuals with limited income and assets, as well as the disabled, blind, and youth under 18 years of age. Medicare is health care for individuals over 65, regardless of income or disability, and pays for limited nursing home stays that occur after a hospital stay. Veterans who are very low income and have less than $3,000 in assets would have Medicaid available to pay for a nursing home stay in a private nursing home that accepts Medicaid.

[33] The Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L.No. 109-461) equalized the cost of nursing home care for these veterans regardless of the setting, and included a provision, effective March 21, 2007, for the VA to use higher per diem rates when reimbursing state veterans homes (SVHs) for providing care to veterans who had a 70 percent service-connected disability or individual unemployability. Pub.L. No. 109-461 also stipulated that SVHs reimbursed at the higher per diem rates were not eligible to receive funding from other federal sources such as Medicare or Medicaid.

At this time, the Minnesota state homes are not qualified to bill for Medicare or Medicaid. If the homes do bill for Medicaid or Medicare, the federal per diem can no longer be collected for that patient. Under Medicare Part A, the home will no longer be able to bill the veteran for a maintenance fee (private pay) either. In a cost-benefit analysis done by MDVA for the use of Medicaid and Medicare payments, they ran two models. The first assumed that all the admissions and operations procedures remained the same, because there are less skilled nursing services provided and less resident days at the state veterans homes; the Medicare Part A revenue stream is not cost effective for the smaller homes and provides only a slight bump in revenue to the Minneapolis home. There is a net gain of approximately $74,000 per year after the decrease to the three smaller homes that provide skilled nursing care is subtracted from the total increase in revenue for the Minneapolis home. If the industry standard practices were used, including accepting a higher volume of residents that qualify for skilled nursing services under Medicare Part A, changing the admissions policies, and adding additional staff and billing staff, then the cost of becoming Medicare certified pays for itself and there is an increase in revenue for all the applicable homes.

The analysis for Medicaid is similar to the analysis for Medicare. Based on the current resident population, with a lower than average acuity and management practices, the Medicaid rates are lower for the state veterans homes than for community nursing homes. There are still additional costs incurred to operate under the Medicaid program but four out of five homes benefit from using Medicaid. The estimate in this analysis is that 10 percent of the population in the state's veterans homes would qualify for Medicaid. All of the homes benefit if industry standards were implemented and residents needing higher levels of care were accepted. An additional document provided by MDVA in August 2013 shows that only 12 patients in the Minneapolis home are eligible for Medicare Part A, that 118 patients are eligible for Medicare Part A and B, and finally that only six patients would be eligible for Medicaid.

Recent correspondence from MDVA cautions that the homes still have to achieve CMS certification and that once certified, they have get residents to be willing to enroll. They indicate they may not be able to force residents to enroll, however the rules governing admission require residents to apply for all benefit programs they are eligible for, so it seems reasonable that eligible residence could be required to use the program. Legislative changes could require patients to enroll if eligible. It also indicates that using Medicare Part A would likely be only in very limited circumstances because that program only covers a 100-day rehabilitative stay after a three-day hospital stay, which is not how most patients are admitted to the state veterans homes.

Having the homes CMS certified would require the homes to undergo DHS inspections as required by the certification. This would increase regulations and scrutiny of the home's health and safety standards and increase the complexity of billing. MDVA indicates that they have already started training staff at the CMS level and are preparing for the billing requirements. DHS employee Robert Held indicated in testimony provided on October 2, 2013, to the committee that the percentage of individuals over 85 years of age that are using nursing homes continues to fall and that currently nursing homes in Minnesota have the lowest occupancy rate ever recorded at 90 percent. Mr. Held indicated that in Minnesota approximately 57 percent of nursing home stays are paid for by Medical Assistance (17.7 percent by Medicare and 48 percent by Medicaid), and 23 percent is private pay. The last 12 percent is other payment and may include veterans contract nursing home payments from the federal VA. The state would likely need legislation to approve the nursing home beds in the state veterans home for CMS

certification due to the moratorium on nursing home beds. Mr. Held emphasized that the state is moving away from nursing homes as a policy and is improving home and community-based services to assist the elderly to age in place.

The full cost of care rate for the Minnesota state veterans homes is determined by the average daily rate of what it costs to run the entire facility to provide care and is effective July 1 of each year. The maintenance cost is a percentage of the full cost of care after deductions and personal allowance are subtracted from their income. A resident with more than $3,000 in assets pays the full cost of care until their assets are below $3,000.[34] A 2010 legislative audit report found that 5 percent of Minneapolis state veterans home residents paid the full cost of care. The full cost of care is higher for spouses who do not receive any federal per diem. Many spouses also do not have income or assets and thus are unable to pay the full cost of care. In 2012, the state paid approximately $5.65 million for the care of approximately 61 spouses in the state veterans' homes.

The new 2013 full cost of care for some of the Minnesota homes was effective July 1, 2013; the veterans rate for care is significantly lower than a nonveteran spouse due to the federal VA per diem paid for veterans. MDVA indicates that the homes do not calculate the cost of care per resident, but instead do a full cost of care per type of bed, so the monthly cost of care for a skilled nursing home bed at the Minneapolis home is $9,939.56. The Fergus Falls veterans home full monthly cost of care for 2013 is $5,700.39 for a veteran and $8,652.92 for a spouse for skilled nursing care. The Luverne state veterans home's full cost of care is approximately $5,576.40 per month for a veteran and $8,488.50 for a nonveteran spouse for skilled nursing care. The Hastings veterans home full monthly cost of care for a veteran resident is $2,702.22 per month; this facility only allows veterans and only provides domiciliary care (assisted living).

MM/nh
Attachments

[34] Minnesota Administrative Rule, part 9050.0755.

APPENDIX D

STATE OF MINNESOTA
HOUSE OF REPRESENTATIVES

FIRST MEETING
EIGHTY-EIGHTH SESSION

SELECT COMMITTEE ON VETERANS HOUSING
Chair, Representative Jerry Newton

MINUTES

Representative Newton, Chair of the Select Committee on Veterans Housing, called the meeting to order at 10:11am on October 1, 2013 in Room 200 of the State Office Building.

The Committee Legislative Assistant noted the roll.

Members present:
Newton, Chair
Clark
Dettmer
Hausman

Testimony regarding Veterans homelessness:
Katie Topinka, Legislative Affairs, Minnesota Housing Finance Agency
Tonja Orr, Assistant Commissioner for Housing Policy, MHFA
Kathleen Vitalis, President and CEO, Minnesota Assistance Council for Veterans
Reggie Worlds, Deputy Commissioner of Programs and Services, Minnesota Department of Veterans Affairs
Chris Ronning
Milton Schoen, Minnesota Association of County Veterans Service Officers
Mike Gallucci, Deputy Commissioner of Veterans Health Care, MDVA

The committee recessed at 11:47am.

The committee reconvened at 1:35 pm.

Testimony regarding Veterans housing options:
Mary Mullen, House Research
Melony Butler, Director, Eagle's Healing Nest
Kathleen Vitalis, President and CEO, MAC-V
Mike Gallucci, Deputy Commissioner of Veterans Health Care, MDVA

The meeting was adjourned at 2:51pm.

Representative Jerry Newton, Chair

Tim Gabhart, Committee Legislative Assistant

STATE OF MINNESOTA
HOUSE OF REPRESENTATIVES

SECOND MEETING
EIGHTY-EIGHTH SESSION

SELECT COMMITTEE ON VETERANS HOUSING
Chair, Representative Jerry Newton

MINUTES

Representative Newton, Chair of the Select Committee on Veterans Housing, called the meeting to order at 9:07am on October 2, 2013 in Room 200 of the State Office Building.

The Committee Legislative Assistant noted the roll.

Members present:
Newton, Chair
Dettmer

Testimony regarding Veterans long term housing:
Bob Held, Director, Nursing Facility Rates and Policy, Continuing Care, Minnesota Department of Human Resources
Helen Roberts, Fiscal Analyst, House Research
Michael Galucci, Deputy Commissioner for Health Care, Minnesota Department of Veterans Affairs
Robin Gaustad, Senior Director of Veterans Health Care, MDVA
Nick Kakos, Minneapolis, MN
Jean Lee, Children's Hope International

The meeting was adjourned at 11:24am.

Representative Jerry Newton, Chair

Tim Gabhart, Committee Legislative Assistant

APPENDIX E

Minnesota Assistance Council for Veterans

Serving Veterans Throughout Minnesota

Radichel Townhomes, Mankato, MN

Permanent Supportive Housing for Disabled Veterans

Radichel Townhomes

Paul & Dorothy Radichel Veteran Town Homes is a three building, 11 unit complex opened in 2006. Each unit is a ground level, one bedroom town home. Each resident must be a homeless veteran with a disability.

Owner/ Sponsor: MN Assistance Council for Veterans

Developer: MN Assistance Council for Veterans

Property Management: MN Assistance Council for Veterans

Service Provider: MN Assistance Council for Veterans

Tenant Profile: Honorably discharged homeless veterans with a disability.

Service Approach: Radichel Veteran Town Homes is an alcohol, drug and violence-free community providing needed permanent supportive housing for veterans with disabilities.

Key Features and Innovations:

- Radichel has had extensive community involvement. The local legion and VFW donated furnishings for the community room. Veterans are transported to the VA in Minneapolis by the Nicollet and Blue Earth county VSO vans. A local appliance store and the state prison system have donated televisions.
- The center building has a community room with a kitchen and full laundry facilities for residents.
- Monthly meetings with all clients in the community room to share ideas and provide a social network among all tenants.
- The residents plant a garden each year and donate fresh vegetables to the local community and food shelf.

Financing

Capital	
CSH	$50,000
HUD (SHP)	$400,000
MHFA	$464,588
GMHF	$100,000
Total	$1,014,588
Operating/Services	
HUD (SHP)	$152,250

About Minnesota Assistance Council for Veterans

MACV exists to directly help veterans and their families affected by homelessness or those in danger of becoming homeless. It also strives to serve, inform, educate and train others to carry a message of hope. As a result, MACV aims to set a national standard for respectfully meeting housing and supportive service needs of veterans while maintaining the worth and dignity of all those involved. Through outreach offices in Minneapolis, Duluth, and Mankato, MACV provides and coordinates services for veterans in need throughout Minnesota.

MINNESOTA ASSISTANCE COUNCIL FOR VETERANS

MACV

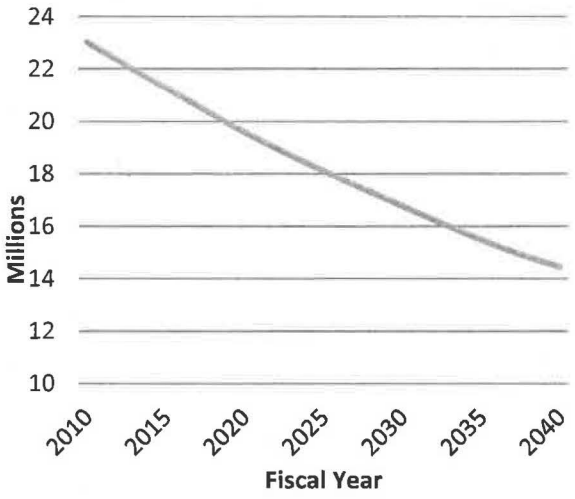
SERVING VETERANS THROUGHOUT MINNESOTA

www.mac-v.org

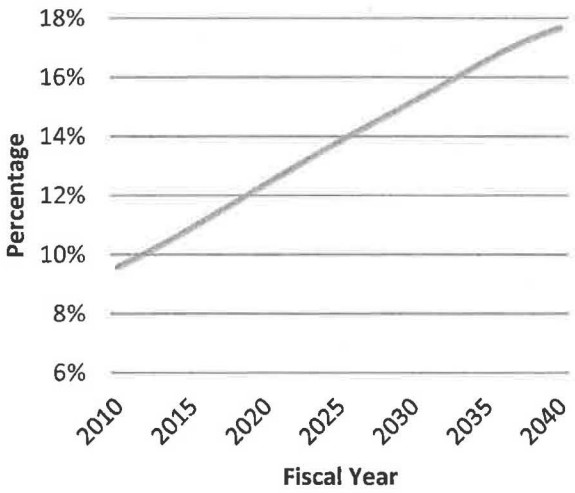
APPENDIX F

Veteran Population Projections: FY2010 to FY2040

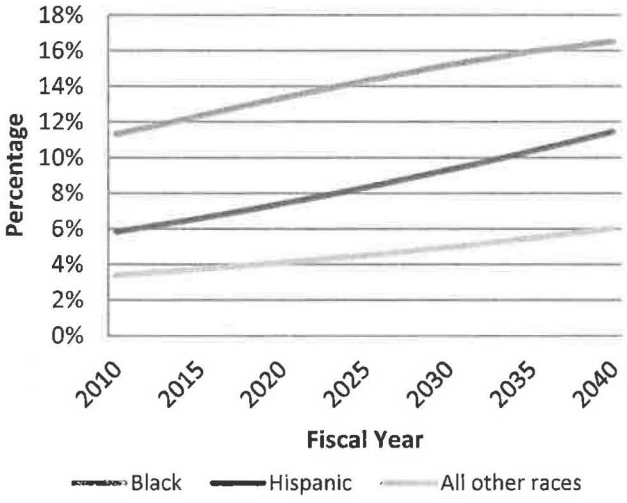
Projected Total Veteran Population 2010 to 2040



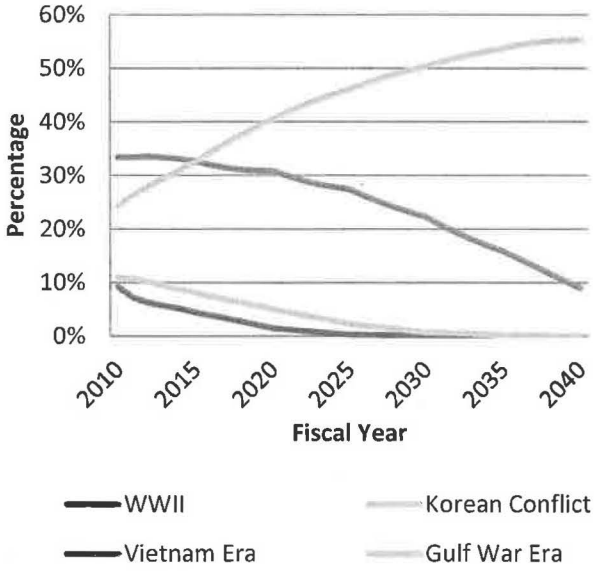
Projected % of Female Veteran Population 2010 to 2040



Projected % of Minority Veteran Population 2010 to 2040



Projected % of Total Veteran Population by Period of Service, 2010-2040



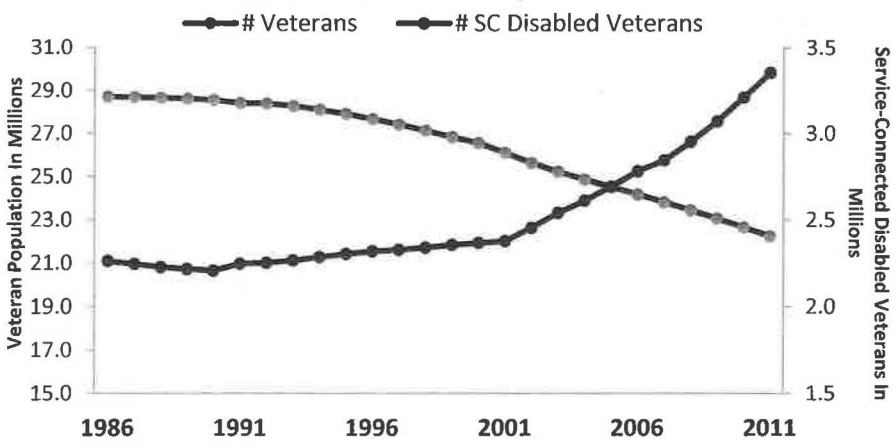
Note: Categories are mutually exclusive.
'All other races' includes American Indian/Alaska Native, Asian, Pacific Islander, and Other.

Source: Office of the Actuary, Veteran Population Projections Model (VetPop2011) tables 1L, 3L and 2L.

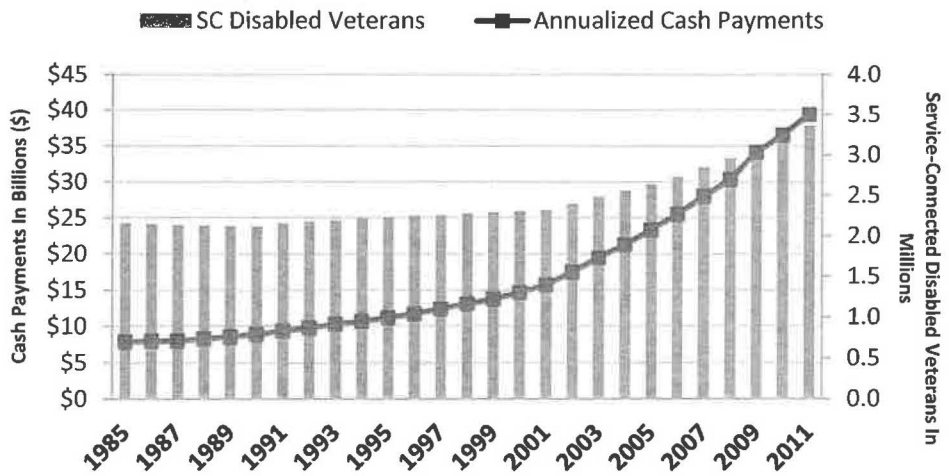
Office of The Actuary, Department of Veterans Affairs

Trends in Veterans with a Service-Connected Disability: FY1985 to FY2011

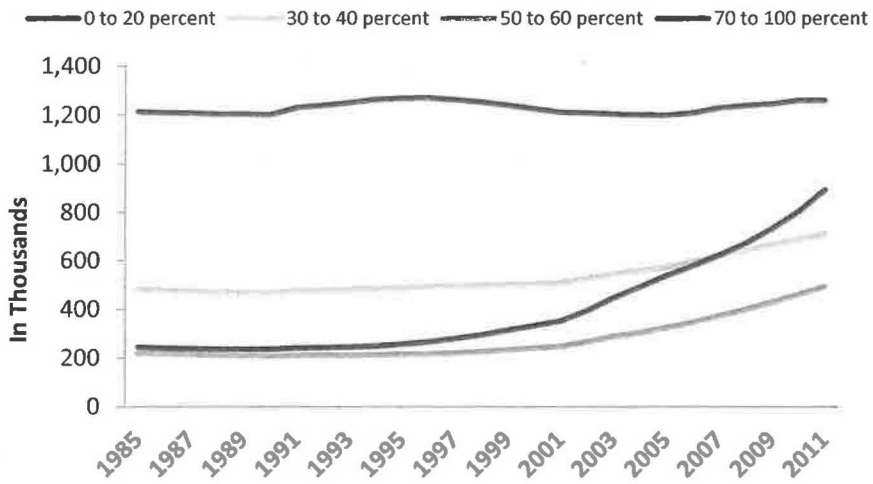
Number of Veterans with a Service-Connected Disability



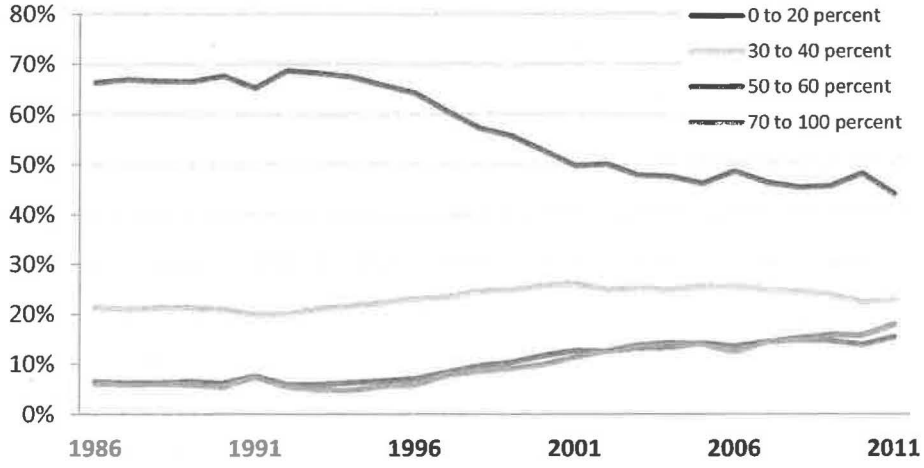
Expenditures for Veterans with a Service-Connected Disability



Total Number of Veterans with a Service-Connected Disability, by Disability Rating and Fiscal Year



Percentage of New Compensation Beneficiaries, by Service-Connected Disability Rating and Fiscal Year



Source: Department of Veterans Affairs, Veterans Benefits Administration Annual Benefits Reports, 1985-2011; Office of Policy & Planning, Office of the Actuary, Veteran Population Projection Model (VetPop), 2007.

Prepared May 2012.

NCVAS National Center for Veterans Analysis and Statistics

APPENDIX G

HUD-VASH Distribution in Minnesota 2008-2012

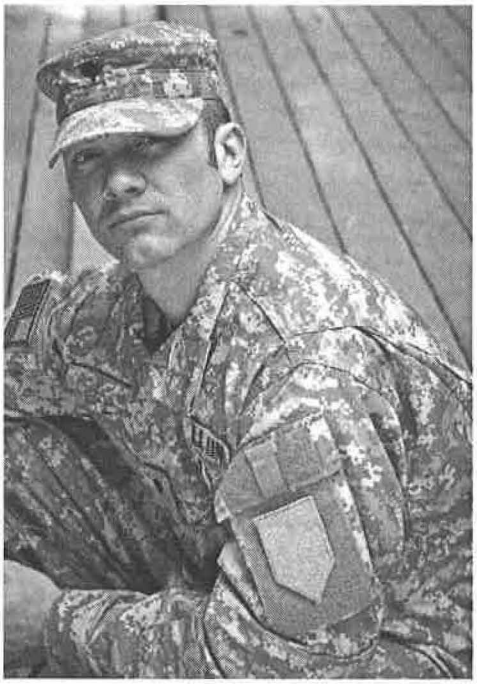
PHA Name	VAMC/CBOC	Location of High Need Where Veterans Should be Identified for Participation	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Total
Public Housing Agency of the City of St Paul	Minneapolis VAMC	St. Paul	0	35	25	25	40	125
Minneapolis HA	Minneapolis VAMC	Minneapolis	70	35	50	50	0	205
HRA of Duluth	Minneapolis VAMC/Hibbing CBOC	Duluth	0	0	0	0	5	5
HRA of St. Cloud	St. Cloud VAMC	St. Cloud	0	35	0	25	15	75
Mankato EDA	Minneapolis VAMC	Mankato	0	0	0	0	5	5
Olmsted County HRA	Minneapolis VAMC/Rochester CBOC	Rochester	0	0	0	0	10	10
Metropolitan Council	Minneapolis VAMC	Minneapolis	0	0	0	0	50	50
		Total	**70**	**105**	**75**	**100**	**125**	**475**

The Department of Veterans Affairs (VA) and the Department of Housing and Urban Development (HUD) established the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program to serve the neediest, most vulnerable homeless veterans and their immediate families. Through its partnership, HUD provides housing assistance to veterans through its Housing Choice Voucher (HCV) program, which allows homeless veterans to rent privately owned housing. VA provides case management, clinical services, and other supportive services through its VA Medical Centers (VAMCs). For additional information go to: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/vash

Below is the number and distribution of VASH vouchers in the state of Minnesota for 2008 to 2012. In 2013, allocations have been provided as follows: St Paul: 15 vouchers; Dakota County: 25 vouchers. Additional vouchers are expected to be awarded to the state in the second round of 2013 funding. To date, there has been one project-based voucher proposal submitted and approved. It was for the Minneapolis VA and it was for 11 units.

Veterans with vouchers rent units from private landlords. It is possible that some of those private landlords have complexes that are fully occupied and have waiting lists, but that would be a function of the private market.

APPENDIX H



Homeless veterans in Minnesota 2012

Statewide survey of veterans without permanent shelter

NOVEMBER 2013

Prepared by:
June Heineman, Greg Owen and Karen Ulstad

451 Lexington Parkway North | Saint Paul, Minnesota 55104
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Wilder Research
Information. Insight. Impact.

Contents

Figures

Acknowledgments

This report, and other companion reports and fact sheets that describe the results of Wilder Research's eighth triennial study of homelessness in Minnesota, would not be possible without many helping hands. This study is, by its very nature, an exercise in cross-sector collaboration and there are many people to thank.

First, thanks to our funders, who always seem to find the resources necessary to bring this study to life. This year, much of the heavy lifting was done by the Minnesota Department of Human Services and Minnesota Housing, who together with the Minnesota Departments of Education, Veterans Affairs, Corrections, and Public Safety, provided half of the resources necessary to complete the study. Private funders also played a critical role by providing the other half of the funding needed. This includes F.R. Bigelow Foundation, Blandin Foundation, Bush Foundation, Family Housing Fund, Greater Minnesota Housing Fund, Greater Twin Cities United Way, The McKnight Foundation, The Minneapolis Foundation, and the Wilder Foundation.

As often is the case, there is a key leader whose persistence and passion make the funding come together. Special thanks are due to Jane Lawrenz at the Minnesota Department of Human Services, who goes to bat in each study cycle to be sure the statewide homeless study and the companion study of reservation homelessness get the attention needed and the funding required, making both studies possible. The authors are also grateful to Kathy Vitalis, president of the Minnesota Assistance Council for Veterans, for her efforts to encourage veterans and veteran serving agencies to participate in the survey. She has been a longstanding and helpful advisor to this study.

Thanks also to Boston Scientific, who provided their facilities and technical assistance to produce our training video, and to Cummins Power Generation, Beacon Interfaith Housing Collaborative, and Wells Fargo for their special efforts recruiting staff to serve as volunteer interviewers.

Volunteer interviewers and service providers are not only the backbone of this study; they also raise awareness about homelessness through the many friends, co-workers, and family members each one touches. This year, community volunteers, agency and program staff, and virtually the entire Wilder Research work force went to 390 locations across the state to conduct interviews. The study would not be possible without them. They endure our training videos and instructional materials, and still find the courage to return for the next study cycle. They are special people.

Finally, all social science research depends on the willingness and participation of the individuals who make up the population of interest; in this case, adults and youth throughout Minnesota who have no permanent place to live. Despite the depth of the survey and the personal nature of many questions, participation rates are extremely high (90%). Respondents answer more than 300 survey questions in face-to-face interviews and receive in exchange only a $5 honorarium. Their generosity in sharing the details of their lives gives voice and substance to the reality of homelessness in our state and helps planners, funders, and advocates in their efforts to find solutions. This report tells their stories.

Wilder Research project staff

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Lisa Sell
Rebecca Schultz
Ellen Shelton
Karen Ulstad

Key findings from the survey

Homelessness among veterans in Minnesota has decreased since 2009

Targeted efforts to reduce homelessness among military veterans appear to be paying off. In 2012, 580 homeless veterans were counted on the night of the survey, down from 669 in 2009. Our survey counted 542 male veterans, a 10 percent decline from the 605 counted in 2009. Among female veterans the decline is even more dramatic: our survey counted 38 female veterans compared to 64 female veterans three years earlier, a drop of 41 percent. Minnesota's trend is similar to the national trend reported by the United States Interagency Council on Homelessness, Ending Homelessness among Veterans (USICH, February 2013), that found the number of veterans experiencing homelessness in the United States has decreased by 18 percent since 2010 (from 76,329 to 62,619).

Most homeless veterans are older and home-grown

While nearly a quarter of homeless adults age 55 and older have served in the military only 7 percent of those 54 or younger have done so. More than half of male homeless veterans in Minnesota are over age 50 compared with about one-quarter of Minnesota's overall male homeless population. On average, male veterans are about 10 years older than the general population of homeless men. Seventy percent of all homeless veterans have lived in Minnesota five years or longer and over half have lived in Minnesota more than 20 years.

Homeless veterans are disproportionately people of color

About 37 percent of Minnesota's homeless veterans are persons of color compared with less than 11 percent of the state's overall population. Particularly over-represented are African Americans in the Twin Cities 7-county area (33%), and both African Americans (11%) and American Indians (10%) in greater Minnesota.

One-quarter of homeless veterans reported serving in a combat zone

Ten percent served in a combat zone in Vietnam, 4 percent in the first Gulf War, and 8 percent in the current Iraq War or Afghanistan. Nearly half of homeless veterans reported service-related health problems, primarily mental health problems (44%) and hearing/ear problems (33%). Based on a series of standard health interview questions, 6 percent of veterans reported that they have been diagnosed with a service-related head injury, although a much higher percentage – one third of all veterans – screened positive for a likely brain injury.

For homeless vets, better education doesn't translate to employment; health barriers play a role in high unemployment rates

Almost all homeless veterans have completed high school compared with just three-quarters of the general homeless population. The percentage who attended college was also higher for homeless veterans than for the general homeless population (50% vs. 34%). However, similar to the overall homeless population, only 9 percent of homeless veterans were employed full time. More concerning, 53 percent of homeless veterans have been unemployed for over a year, compared with 46 percent of the overall homeless population. It is important to note that over half of homeless veterans reported that a physical, mental, or other health condition limited the amount or type of work they could do, and nearly one-third reported problems with memory, concentration, or decision-making.

Homeless vets have high rates of health coverage and access to care, but medical needs are not always met

More than 4 out of 5 homeless veterans have some type of medical coverage and 78 percent report that they have a regular place to go for medical care. Nonetheless, among the veterans we surveyed, 49 percent say they need to see a dentist, 43 percent need to see a doctor for physical health problems, and 36 percent need to see a professional for mental health problems. Overall, 26 percent report problems getting the medical care that they need, one out of six was not taking prescribed medications, and 42 percent had sought care in an emergency room within the past six months.

Use of veterans benefits is up

In the year prior to the survey, 45 percent of homeless veterans took advantage of benefits provided them. This compares to 42 percent in 2009 and 33 percent in 2006. The benefits most frequently used were Veterans Administration medical services (34%) and service-related compensation (19%). In addition, about one-third (34%) of homeless military veterans reported that during the past 12 months they had contact with a County Veterans Service Officer and over one-quarter had attended a Veterans Stand Down event.

Veterans experience high levels of chronic homelessness

Nearly 6 out of 10 homeless veterans have been without stable housing for a year or longer. One out of 4 has been homeless at least three years, five percentage points higher than the overall homeless population. The proportion of homeless veterans that fit Minnesota's definition of long-term homeless was 63 percent; the proportion of homeless veterans that fit HUD's definition of chronic homeless was 46 percent.

Addressing veterans' homelessness

According to the USICH report, Veterans Administration program staff and grantees have been working on a variety of engagement strategies designed to fit the individual needs of returning veterans. These strategies include short-term assistance to help veterans connect to mainstream services, transitional services for completing treatment or rehabilitation and securing permanent housing, along with rent subsidy and case management services. Brief descriptions of these programs are presented on page 17 of this report.

Introduction

The purpose of this report is to provide a current snapshot of U.S. military veterans experiencing homelessness in Minnesota. The information is intended as a resource for planners, policymakers, service providers, and others who are interested in addressing the problems associated with homelessness among veterans.

The information presented in this report is a subset of data from the statewide survey and comes from three main sources:

1. A statewide population count, or census, of all persons who were residing in emergency shelters and transitional housing facilities on the night of Thursday, October 25, 2012.

2. A statewide survey of a sample of military veterans (N=441) who were living in emergency shelters and transitional housing facilities on October 25, 2012.

3. A survey of 139 homeless veterans found in informal or non-shelter locations around the state on October 25, 2012.

The report also references U.S. Census information and other data about the general adult population.

Other reports and detailed data tables on homeless adults and their children, youth and young adults, and on Minnesota's Continuum of Care regions are available at: http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/default.aspx

Background

Every three years since 1991, Wilder Research has conducted a statewide survey of people who are homeless or living in temporary housing programs. In October 2012, nearly 1,300 volunteer interviewers conducted face-to-face interviews with more than 4,500 people experiencing homelessness throughout the state. Study participation was voluntary, and participants received $5.00 for completing the interview. Ninety percent of those who were asked agreed to participate. This report is based on those in the statewide study who identified themselves as having served in the U.S. military.

Data sources

The statewide homeless study is based on two sources of data: face-to-face interviews with adults and unaccompanied youth experiencing homelessness, and a shelter census completed by the shelter providers.

Interviews

The statewide survey provides information about the characteristics of homeless people based on 4,563 face-to-face interviews with homeless adults and youth, each one typically lasting 35 to 45 minutes. The interviews were done by 1,299 volunteers and program staff in 390 locations, including shelters and transitional housing programs as well as meal sites, service centers, encampments, and other places not intended for housing. Interviews were conducted in October 2012 with respondents known to be homeless on the night of October 25, including 1,502 men and 1,428 women in shelters, as well as another 1,535 interviews with adults in non-shelter locations. According to the interviews, adult respondents had 2,347 children and 704 partners with them. We also conducted interviews with 98 unaccompanied minors age 17 and under, both in and out of shelter settings. These minors had a total of 6 children and 12 partners with them.

According to the interviews, 580 homeless persons identified themselves as having served in the U.S. military. There were 542 men and 38 women. They had a total of 49 children with them on the night of the survey.

Based on prior information from shelter providers, the statewide survey was translated into the languages most often needed. Seven interviews were completed in Somali and 28 were completed in Spanish.

Shelter census count

Detailed information about the total number of men, women, and children in residence on the night of the survey is gathered from all providers of service in emergency shelters, time-limited transitional housing programs, domestic violence shelters, and emergency service voucher sites. This complete enumeration within shelters on the day of the survey provides the basis for all shelter counts reported here. It also allows us to weight the survey results for those in shelters and generalize the findings to nearly the entire population of those experiencing homelessness in our state.

The shelter census counts are used to produce a detailed count for each Continuum of Care region (geographic areas used for housing planning and service coordination) in Minnesota and are posted on the Wilder Research website at http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/default.aspx. There is no comparable information about the total number of persons in non-shelter locations, other than the counts of those who participated in interviews and persons staying with them in non-shelter locations. All adults and unaccompanied youth found in non-shelter locations were asked to participate in the study (or one member of each couple).

Who is included in the study

Definition of homelessness

The definition of homelessness used for the study is the same one specified by the U.S. Congress in its most recent reauthorization of the Hearth Act. For the 2012 study, a homeless person is anyone who:

1. lacks a fixed, regular, and adequate nighttime residence; **and**
2. has a primary nighttime residence that is a supervised, publicly- or privately-operated temporary living accommodation, including emergency shelters, transitional housing, and battered women's shelters; **or**
3. has a nighttime residence in any place not meant for human habitation, such as under bridges or in cars.

A parent not meeting any of these criteria may be included if they have a child with them, and have a significant history of residential instability, and have a barrier (or have a child with a barrier) that interferes with housing or employment.

Where interviews were done

Interviews were conducted in shelters and temporary housing programs and also in non-sheltered locations.

We distinguish three types of ***shelter programs*** that serve homeless people:

- **Emergency shelters** – A safe place to sleep, generally open only evenings and overnight. May provide meals, housing information and other services.
- **Battered women's shelters** – Safe refuge and advocacy for women and their children when fleeing an abusive situation.
- **Transitional housing** – Time-limited, subsidized housing that involves working with a professional to set and address goals to become self-sufficient.

For homeless people interviewed who were ***not in shelters*** on the date of the study, information in the survey gives some insight into the settings in which they had spent the most time in October. For analysis and reporting, we have identified two groups:

- **Informal arrangements** – People in this group were more likely to be in a house, apartment, or room in which they were allowed to stay on a temporary basis; or a motel room that they paid for (not provided by a voucher program). They were less likely to be outdoors.

- **Unsheltered** – People in this group were more likely to be in cars, transportation depots, 24-hour businesses, buildings that are abandoned or unfit for habitation (lacking plumbing, electricity, or heat), or outdoor locations. They were less likely to be in informal arrangements staying with others on a temporary basis.

Unless otherwise stated, percentages reported are based on all homeless adults who are represented in the survey.

Using this report

This report provides overall findings from a subset of data from the 2012 study based on interviews conducted with homeless persons who identified themselves as having served in the U.S. military. Because of changes in programs and services, and variations in outreach efforts in different regions of Minnesota, caution should be exercised in making direct comparisons to results from previous years, except comparisons presented in this report.

In this report, we present most homelessness information in terms of overall statewide frequencies or averages. There is a wealth of information in this report, but it is still possible that the specific fact a reader may be looking for is not here. In that case, it is likely to be found on our website: http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/default.aspx where detailed responses to each survey question are available in tabular form, partitioned by geography, shelter type, and gender of respondent.

Interpreting the findings

This is a point-in-time study. If the study were extended over the course of a year, many more short-term episodes of homelessness would occur, but relatively few additional long-term episodes would be added to those already documented here. Therefore, when interpreting these findings, it is important to bear in mind that they better represent the experiences of those who are homeless for lengthy periods of time (or repeatedly) than for those whose experiences of homelessness are short.

The total number of responses to a given question is not always the total number of people in the survey. Not all questions were asked of every respondent (for example, questions about children were not asked of those who have no children). Not all respondents answered every question.

Understanding data weighting

It is not possible to interview every person staying in shelters on the date of the survey, although in 2012, nearly two-thirds (62%) of sheltered adults were interviewed. Survey results for sheltered adults have been statistically adjusted to reflect the actual adult populations residing in emergency shelters, battered women's shelters, and transitional housing programs (2,326 men and 2,412 women) on the day of the survey.

We do not weight the data collected from persons interviewed in non-shelter locations, because we do not know the actual number of people who were on the streets or in other non-shelter locations on the day of the survey.

Overview

This study gives a snapshot of U.S. military veterans experiencing homelessness in Minnesota on a single day in October 2012. The findings reported here are based on interviews with 412 male veterans and 28 female veterans conducted on Thursday, October 25, 2012. Interviews, as part of the statewide survey of people without permanent shelter in Minnesota, were weighted to represent the known population count of adults residing in emergency shelters and transitional housing facilities. The known number of veterans in Minnesota's temporary housing programs was 441 veterans (414 men and 27 women). An additional 139 veterans (128 men and 11 women) were interviewed in non-shelter locations. Interviews with people in non-sheltered locations were not weighted, because there is no way to determine the total population in such settings. In all, the 2012 study identified 580 homeless veterans, including 542 men and 38 women, residing in emergency shelters, battered women's shelters, and transitional housing programs or in non-sheltered locations. These homeless veterans were accompanied by 49 children.

Highlights

Numbers of homeless

According to the overall statewide study conducted on October 25, 2012, shelter providers counted 7,961 homeless people in emergency shelters, battered women's shelters, and transitional housing programs, as well as 32 homeless persons in detox facilities. An additional 2,221 homeless people were identified who were not staying in any formal shelter or housing program, for a total of 10,214 homeless persons. The total is made up of 3,423 men; 3,067 women; 66 male unaccompanied minors under 18; 80 female unaccompanied minors under 18; and 3,546 minor children who were with their parents. (Age and gender are not known for the 32 persons in detox.)

- About one in ten (9%) homeless adults had served in the military, a proportion that is the same as in the overall adult Minnesota population and a result that is similar to previous surveys.[1]

- The proportion of homeless men who are military veterans (17%) is much higher than the proportion of women (1%).

- Homeless adults age 55 or older are more likely to have served in the military than those 54 or younger (24% vs. 7%).

[1] U.S. Census Bureau. *2011 American Community Survey 1-year Estimates* [statistics from data file]. Retrieved May 1, 2013, http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Compared with the general adult population experiencing homelessness, the number of U.S. military veterans experiencing homeless has decreased. The percentage of homeless adults who are veterans decreased from 22 percent in 1991 to 9 percent in 2012. Veterans, as a percentage of men experiencing homelessness, have also declined (34% in 1991 to 17% in 2012). The following figure shows the weighted numbers and percentages of homeless veterans described over the eight study periods.

1. Number and percentage of homeless persons who are U.S. military veterans

	Men		Women		Total	
	N	%	N	%	N	%
October 1991	417	33.7%	21	2.7%	438	21.8%
October 1994	322	25.4%	32	2.6%	354	14.3%
October 1997	350	26.3%	24	1.6%	374	13.2%
October 2000	686	30.7%	50	2.4%	686	16.4%
October 2003	652	26.1%	50	2.2%	702	14.7%
October 2006	595	23.9%	29	1.3%	624	13.2%
October 2009	605	19.3%	64	2.3%	669	11.3%
October 2012	542	16.5%	38	1.3%	580	9.3%

Who is homeless?

- The vast majority of homeless veterans were males (93%). The average age of homeless male veterans was 50, and the average age of homeless female veterans was 33. Nearly half (48%) of homeless veterans reported that they were divorced or separated (38% and 10%, respectively). The percentage of homeless veterans who had never married was lower than that of the general homeless population surveyed in 2012 (43% vs. 63%).
- Less than one-quarter (23%) of homeless veterans interviewed on the night of the survey had lived in Minnesota for two years or less. Over two-thirds (70%) of the veterans surveyed had lived in Minnesota for more than five years, including over half (52%) who had lived in Minnesota for more than 20 years.
- Homeless veterans were disproportionately people of color. Particularly over-represented were African Americans in the Twin Cities area (33%), and both African Americans (11%) and American Indians (10%) in greater Minnesota.[2] While less than 11 percent of the state's overall population is made up of persons of color, nearly two-fifths (37%) of Minnesota's homeless veterans were persons of color.

[2] Throughout this report, the "Twin Cities area" refers to the seven counties of Hennepin, Ramsey, Anoka, Carver, Scott, Dakota, and Washington.

- Veterans interviewed in informal and unsheltered locations were predominantly male (91%), and over half (59%) had been homeless for a year or longer. American Indian veterans (16%) and African American veterans (15%) veterans made up about one-third of those interviewed in informal and unsheltered locations.
- Half (50%) of homeless veterans interviewed had served in the Army; 16 percent served in the Navy; 16 percent served in the Marine Corps; 9 percent served in the National Guard; 6 percent served in the Air Force; and 3 percent served in the Reserves.
- Two-thirds (67%) of homeless veterans had served for more than two years; 21 percent for 181 days to two years; 6 percent for 90 days to 180 days; and 6 percent for less than 90 days.
- One percent of the homeless veterans began their military service prior to August 1964; 22 percent between August 1964 and May 1975; 22 percent between June 1975 and September 1980; 46 percent between October 1980 and March 2003; and 10 percent April 2003 or later.
- One-quarter (26%) of homeless veterans reported having served in a combat zone. Ten percent of homeless veterans reported they had served in a combat zone in Vietnam; 8 percent in the current Gulf War, Iraq or Afghanistan; 4 percent in the first Gulf War; 1 percent in Panama; 1 percent in Granada; 1 percent in Lebanon/Beirut; and less than 1 percent each in Korea and Serbia/Bosnia.

Children of homeless veterans

- Although 152 homeless veterans (26%) reported having children under the age of 18, only 34 parents (22% of parents) had any children with them on the night of the survey. Those parents represented 5 percent of all homeless veterans surveyed.
- Of the 34 homeless veteran parents who had children with them, nine parents (26%) reported they had been unable to obtain needed child care in the previous 12 months; six parents (18%) had been unable to obtain needed dental care; four parents (11%) had been unable to obtain needed health care; and three parents (8%) had been unable to obtain mental health care for at least one of their children. Two (6%) of the homeless parents reported that their children had to skip meals in the last month.
- Ten (28%) homeless veteran parents who had children with them reported having at least one child who has an emotional or behavioral problem that interferes with their daily activities. Two homeless parents (7%) reported having at least one child who has a physical health problem that interferes with their daily activities.

- Twenty-three homeless veteran parents had a least one school-age child with them. Ten parents (42%) reported that their child has been a victim of bullying; four parents (21%) reported that at least one of their school-age children has some type of learning or school-related problem; and 5 parents (23%) reported having a child who has repeated a grade in school. Seventeen (79%) homeless parents reported that their children attended school on the day of the survey, and four parents (17%) reported that one or more children has problems going to school because of their housing situation.

Education, employment, and income

- The percentage of homeless veterans who completed high school was much higher than that of the general homeless population surveyed in 2012 (96% for homeless veterans compared to 77% for the general homeless population). The percentage who had attended at least some college was also higher than for the general homeless population (50% vs. 34%).
- Twenty-two percent of homeless veterans were employed; 9 percent were employed full-time. Of those employed, nearly half (48%) earned less than $10 per hour. Two-thirds (67%) of those who were employed had been at their job for three months or more.
- Those who were not working reported that their main barriers to employment were physical health problems (37%), mental health problems (18%), lack of transportation (17%), lack of job opportunities (14%), criminal background (14%), lack of housing (14%), and age (13%).
- Homeless veterans surveyed reported that their main sources of income in the month of October were General Assistance (26%), steady employment (16%), Social Security Disability Insurance (SSDI) (10%), Supplemental Security Income (SSI) (7%), Social Security (7%), and day labor (7%).
- When asked about their total income for the month of October, 14 percent of homeless veterans reported some income, but $100 or less; 23 percent reported incomes of $101 to $300; 6 percent reported incomes of $301 to $500; 17 percent reported incomes of $501 to $800; and 30 percent reported incomes over $800. Fifty-four (10%) homeless veterans reported having had no income in October. The average income was $637 and the median income was $403.

History of homelessness

- Two-thirds (67%) of homeless veterans had been homeless more than once. Over one-quarter (28%) reported they had been homeless two to three times in their lives; 17 percent had been homeless four to seven times; and nearly one-quarter (22%) had been homeless eight or more times. The average age at which veterans became homeless for the first time was 35; the median age was also 35.

- The proportion of homeless veterans that fit HUD's definition of chronic homeless was 46 percent. The proportion of homeless veterans that fit Minnesota's definition of long-term homeless was 63 percent.
- Nearly one-fifth (19%) of homeless veterans reported having been unable to obtain shelter in the previous three months because of a lack of available beds. Of those, most ended up sleeping outdoors (40%), in cars or other enclosed places not meant for habitation (21%), in another shelter (17%), or with friends or family (11%). Others ended up with a voucher for a motel (7%), in a hospital (2%), or in jail (1%).
- Over one-third (37%) of homeless veterans spent at least one night outdoors during the month of October. The average number of nights spent outdoors was 6. Nearly one-quarter (22%) of homeless veterans spent at least one night during October doubled up with friends or family. The average number of nights spent doubled up was 2.

Residential placements

- Two-thirds (66%) of homeless veterans had lived in at least one kind of institution or residential program in their lives including a drug or alcohol treatment facility (46%), a halfway house (30%), a mental health treatment facility (25%), a group home (20%), or a foster home (17%).
- Over half (56%) of homeless veterans had been in a correctional facility in their lives including in a county jail or workhouse (51%), a state prison (23%), a juvenile detention center (15%), or federal prison (5%).

Housing

- The most common reasons homeless veterans cited for having left their last regular housing were loss of a job or reduction in work hours (38%); inability to afford the rent (37%); eviction (26%); a drinking or drug problem (21%); problems getting along with the people they lived with (20%); or a break-up with a spouse or partner (20%). The most commonly cited current barriers to regaining housing were lack of a job or income (43%), no housing they could afford (21%), a criminal background (18%), or credit problems (17%).
- The average amount homeless veterans reported they could pay for rent, including utilities, was $298 a month. The median amount was $250. About one-third (34%) of homeless veterans could pay something, but $300 or less, for rent. One-quarter (25%) reported they could not pay anything for rent. Nearly three-quarters (72%) needed only an efficiency or studio apartment.

Public assistance and service use

- Seven percent of homeless veterans (5% of men and 45% of women) had received MFIP (welfare assistance) in the previous 12 months.
- About one-fifth (19%) of homeless veterans reported the loss of one or more services or public assistance benefits during the previous 12 months. Those who had lost benefits most frequently reported the loss of food stamps (68%), public medical benefits (34%), and unemployment benefits (14%). One-quarter (25%) of all homeless veterans said they needed help to apply or reapply for services.
- Over four-fifths (83%) of homeless veterans reported having some type of medical coverage in October, and nearly half (48%) reported the use of food stamps in October. Other frequently used services included free clothing shelves (39%), hot meal programs (37%), transportation assistance (35%), state or federal veterans benefits (32%). drop-in centers (31%), food shelves (23%), emergency room (21%), and free medical clinics (19%).
- Over one-third (34%) of homeless veterans reported having had contact with their County Veterans Service Officer during the previous 12 months.
- Over one-quarter (27%) of homeless veterans had attended a Veterans Stand Down event in the previous 12 months.
- Over one-quarter (28%) of homeless veterans had attended a Project Homeless connect event in the previous 12 months.
- Nearly two-thirds (65%) of homeless veterans reported that they have access to a computer with internet access; nearly two-fifths (38%) own a cell phone that can access the internet.
- Two-thirds (67%) of homeless veterans have a Minnesota driver's license or Minnesota state-issued photo ID.

Health and well-being

- Nearly half (47%) of homeless veterans reported a service-related health problem. Of those veterans, over two-fifths (44%) reported a mental health problem and one-third (33%) had ear or hearing related problems. Six percent reported a service-related head injury or traumatic brain injury.
- Over half (54%) of homeless veterans had at least one chronic medical condition (asthma, other chronic lung or respiratory problems, chronic heart or circulatory problems, high blood pressure, diabetes, tuberculosis, hepatitis, or HIV/AIDS). Of those, three-quarters (75%) received care for each such condition in the previous year.

- Half (49%) of homeless veterans said they currently needed to see a dentist; 43 percent needed to see a doctor for a physical health problem; 36 percent needed to see a professional for a mental health problem; and 9 percent needed to see a professional for a chemical dependency problem. More than one-quarter (26%) reported problems getting needed medical care.
- Over three-fourths (78%) of homeless veterans reported they had a regular place to go for medical care. Of those, over two-fifths (43%) received medical care at a clinic that required fees or insurance, and 39 percent received care at a Veterans Administration Medical Center.

Mental and chemical health

- Mental illness is a significant problem among homeless veterans in Minnesota. Half (50%) had been told by a doctor or nurse within the previous two years that they had at least one of the following serious mental health disorders: schizophrenia, manic depression, some type of delusional disorder, major depression, antisocial personality disorder, or post-traumatic stress disorder. Adding those who had received inpatient or outpatient mental health treatment in the previous two years, 57 percent of homeless veterans can be described as having a serious mental health problem.
- The specific mental health disorders reported by homeless veterans included major depression (36%); post-traumatic stress disorder (27%); manic depression (21%); antisocial personality disorder or another serious emotional disorder (17%); paranoia or some other type of delusional disorder (7%); and schizophrenia (8%).
- Nearly two-fifths (37%) of homeless veterans self-report that they are alcoholic or chemically dependent. Over one-quarter (27%) reported being told by a doctor or nurse within the previous two years that they have a drug disorder or an alcohol disorder. Twenty percent of homeless veterans received inpatient alcohol or drug treatment within the previous two years. Thirteen percent of homeless veterans received outpatient alcohol or drug treatment in the previous two years.
- Nearly one-fifth (18%) of homeless veterans have a dual diagnosis of a mental illness and chemical dependency. This is based on the percentage of persons who reported being told by a doctor or nurse within the previous two years that they have a major mental illness (schizophrenia, paranoia, manic depression, major depression, antisocial personality or post-traumatic stress disorder) as well as an alcohol or drug abuse disorder. This is similar to the 16 percent of the statewide homeless population surveyed in 2012 that meet the same criteria of having a dual diagnosis.

Serious or chronic disability

- Over half (54%) of homeless veterans reported that a physical, mental, or other health condition limited the amount or type of work they could do. Nearly one-sixth (14%) reported that a health condition limited their daily activities, and nearly one-third (32%) reported problems with memory, concentration, or decision-making.
- Pooling the above disabilities with chronic medical conditions, mental illness, and substance abuse, 87 percent of homeless veterans had at least one serious or chronic disability.
- One-third (33%) of homeless veterans had a history that suggests likely traumatic brain injury. Thirteen percent have been told by a doctor or nurse within the last two years that that they had a concussion or traumatic brain injury. Six percent reported a service-related head injury or traumatic brain injury.

Abuse and victimization

- Just over one-third (35%) percent of homeless veterans reported physical mistreatment as a child (34% of men and 45% of women), and 18 percent reported they were sexually mistreated as children (18% of men and 30% of women).
- Nearly one-quarter (23%) of homeless veterans (21% of men and 52% of women) had stayed in an abusive situation for lack of other housing options, and nearly one-third (30%) of the female veterans left their previous housing to flee domestic violence. Ten percent of homeless veterans (8% of men and 35% of women) had been in an abusive relationship in the previous 12 months.
- Fifteen percent of homeless female veterans and 5 percent of male homeless veterans had been approached to work in the sex industry.
- Nearly one-sixth (14%) of homeless veterans had been physically or sexually attacked at some time while they were homeless (14% of men and 20% of women), and 8 percent had sought health care for injuries due to violence in the previous year (7% of men and 16% of women).

Effective service strategies

In response to the national priority of ending homelessness among veterans by 2015, the U.S. Interagency Council on Homelessness (USICH) released its plan, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness,* in 2010. According to their February 2013 report, entitled *Ending Homelessness among Veterans: A Report by the United States Interagency Council on Homelessness*, progress has been made in reducing homelessness among veterans, but more needs to be done to meet the goal.

The strategy employed in the federal initiative is to increase the supply of permanent supportive housing, improve access to veteran-centric homeless services, and increase the focus on prevention of homelessness and rapid rehousing. According to the report, the Veterans Administration is the key partner in working with veterans and their families. Their primary objective is to connect veterans and their families with the programs designed to provide them with services that best fit their needs.

The three main program components of the plan are:

- Supportive Services for Veterans Families (SSVF) – This program provides short-term assistance with a focus on making connections to mainstream services and rapidly rehousing those veterans who become homeless.

- The Grant and Per Diem (GPD) and other Residential Rehabilitation programs – These programs provide transitional assistance and supports for those completing treatment and services and exiting to permanent housing. Using what can best be described as a transitional housing model, the program provides rental assistance and supportive services in housing that the veteran can remain in as leaseholder when the assistance is withdrawn.

- HUD-VA Supportive Housing (HUD-VASH) – This program provides a permanent rental subsidy and long-term case management for veterans experiencing chronic homelessness. In collaboration with VA Medical Centers and Public Housing Agencies, the Veterans Administration and HUD are working together using a Housing First model which focuses on getting veterans into permanent housing as quickly as possible. Once housed, caseworkers and other supportive service providers work to improve the quality of life and health for participating veterans.

An early feature of this federal initiative was the development of the National Homeless Registry, a data management tool designed to monitor Veterans Health Administration data, homeless programs' data, and certain community partners' data related to homelessness. It is believed that this data management system will also provide a more accurate count of homeless veterans than the current annual Point-in-Time (PIT) count conducted by the HUD Continuum of Care units across the country.

While generally optimistic, the report acknowledges that,

> *"... it will require continued investment in veteran-centric housing and health programs, the widespread adoption of evidence-based practices such as Housing First and Critical Time Intervention, resource targeting to ensure that veterans receive the proper dose and duration of treatment to achieve the best outcome, and collaboration across all Council agencies to provide increased access to mainstream housing, employment, income, and healthcare resources for Veterans."*

The federal report concludes by calling for a greater commitment from all federal agencies to increase access to mainstream housing and stabilization services. It also calls for an increased investment in HUD-VASH and SSVF programs, especially in communities with the highest demonstrated needs. Finally, it calls for greater local ownership of the goal of ending homelessness among veterans by 2015.

Introduction to survey results

This report presents study results in two ways:

1. A comparison of homeless male veterans to non-veteran homeless men.

2. A descriptive overview of homeless veterans surveyed on Thursday, October 25, 2012.

In addition, detailed data tables that allow readers to examine specific survey questions broken down by locale (Twin Cities area vs. greater Minnesota), gender, and shelter type are available on our Web site: http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/default.aspx.

Comparison of homeless male veterans to non-veteran homeless men

Of homeless persons surveyed in the 2012 statewide study, nine percent (17% men and 1% women) had served in the U.S. military. Ninety-three percent of the 580 homeless persons identified as veterans were men; therefore, unless otherwise stated, the descriptions given below apply only to male veterans.

Homeless male veterans were more likely to be older than other homeless men. They were also more likely to have completed high school, attended some college, and been homeless for a year or longer. Homeless male veterans were less likely to identify as a racial or ethnic minority, be located in the Twin Cities area, or have been homeless before. Although the percentage who were employed was equal, male veterans were slightly more likely to be working full-time.

2. Homeless male veterans compared to other homeless Men

	Male veterans N=542	Other homeless men N=2,741
Average (mean) age	50	40
Age 34 or younger	11%	37%
Located in Twin Cities area	62%	66%
At least a HS diploma or GED	96%	78%
Some college	50%	29%
Racial or ethnic minority	37%	53%
Ever incarcerated	59%	62%
Ever homeless before	66%	70%
Currently homeless a year or longer	60%	55%
Employed	21%	21%
Working full-time (35+ hours/week)	9%	6%

On average, homeless male veterans reported fewer traumatic childhood experiences than homeless non-veterans. Fewer male veterans lived in an out-of-home placement as a child or experienced homelessness before the age of 18. However, approximately equal proportions reported that they had been physically or sexually abused as children.

3. Homeless male veterans compared to other homeless Men – childhood trauma and placements

	Male veterans N=542	Other homeless men N=2,741
Spent a week (or more) in a juvenile detention center	16%	25%
Foster care (as a child)	16%	19%
Group home (as a child)	11%	13%
Drug treatment facility (as a child)	2%	8%
Physically or sexually abused (as a child)	36%	31%
First experienced homelessness before age 18	10%	23%
First experienced homelessness before age 26	27%	52%

Physical and mental health

Homeless male veterans were more likely than other homeless men to have considered suicide or attempted suicide. They were also more likely to have a serious mental illness or have a chronic health condition. Homeless veterans (especially combat veterans) were much more likely to experience Post-Traumatic Stress Disorder (PTSD). Homeless veterans and non-veteran homeless males were about equally likely to have major depression, alcohol abuse disorder, or have a dual diagnosis. Homeless male veterans were slightly less likely to have a drug abuse disorder.

4. Homeless male veterans compared to other homeless Men – health

	Male veterans N=542	Other homeless men N=2741
Service-related health problem (% of combat veterans)	46% (63%)	(n.a.)
Chronic health condition	54%	49%
Post-Traumatic Stress Disorder (PTSD) (% of combat veterans)	24% (43%)	18% (n.a.)
Major depression	34%	33%
Serious mental illness	48%	43%
Ever considered suicide	44%	33%
Ever attempted suicide	26%	18%
Alcohol abuse disorder	23%	21%
Drug abuse disorder	13%	16%
Dual diagnosis (mental health and substance abuse disorder)	17%	18%

Barriers to housing

Homeless male veterans reported housing barriers similar to those reported by other homeless men. Veterans were somewhat less likely to cite criminal history, lack of affordable housing, or alcohol or drug use as current barriers to housing, but more likely to cite credit problems.

5. Homeless male veterans compared to other homeless men – Barriers to housing

Current housing barriers cited by veterans:	Male veterans N=542	Other homeless men N=2741
Credit problems	17%	15%
Criminal history	17%	25%
Lack of affordable housing	21%	25%
Alcohol or drug use	5%	6%

Other current barriers to housing reported by homeless male veterans include the lack of a job, bad rental history, no local rental history, mental health problems, and the cost of application fees.

Barriers to employment

Compared to other homeless men, homeless male veterans were about equally likely to be employed. A slightly higher percentage of homeless male veterans were working full-time (35 hours or more a week). Veterans were more likely to identify physical health problems and age as barriers to employment. Veterans were less likely to identify transportation and criminal history as barriers to employment. A slightly higher percentage of veterans were diagnosed with a serious mental illness within the previous two years (48% vs. 43%); however, about the same percentage of homeless veterans as non-veterans identified this as a barrier to employment.

Homeless male veterans were more likely than other homeless men to have been unemployed for a year or longer (64% vs. 54%). Lack of education (completing high school or GED) was higher among non-veteran homeless men (22% vs. 4%).

Some of these differences may be attributable to the fact that homeless male veterans, on average, are ten years older than other homeless men.

6. Homeless male veterans compared to other homeless men – Barriers to employment

	Male veterans N=386	Other homeless men N=1,913
Employment barriers cited by unemployed veterans:		
Physical health problems	36%	25%
Mental health problems	18%	17%
Transportation	16%	26%
Lack of housing	14%	15%
Age	14%	7%
Criminal history	13%	20%
	Male veterans N=542	**Other homeless men N=2,741**
Potential employment barriers based on survey:		
Mental illness problems	48%	43%
Long-term unemployment (of those unemployed)	64%	54%
Alcohol or drug problems	27%	26%
Lack of education (no high school diploma or GED)	4%	22%

General descriptive profile

Background characteristics

The known number of homeless veterans in Minnesota's temporary housing programs on October 25, 2012, was 441 (414 men and 27 women). An additional 139 veterans (128 men and 11 women) were interviewed in non-shelter locations. Homeless veterans were accompanied by 49 children.

The following results are based on weighted interviews as described on page 43 of this report.

Men made up 93 percent of the homeless veteran population. The average age for men was 50 years and for women, 33 years.

Racial disparities are prevalent in the homeless veteran population. Nearly two-fifths (37%) of homeless veterans in Minnesota were people of color. Survey results indicate that 61 percent of homeless veterans were Caucasian, 24 percent were African American, 6 percent were American Indian, 6 percent were of mixed racial background, and 1 percent identified their race as Asian. Two percent did not specify any race. Four percent of homeless veterans said they were of Hispanic origin.

7. Race and ethnicity of homeless veterans compared to Minnesota adult homeless population and overall Minnesota adult population

	Percent of homeless veterans	Percent of homeless adults in MN	Percent of all Minnesota adults
American Indian	6%	10%	1%
Asian American	1%	1%	4%
Black/African American	24%	38%	5%
White/Caucasian	61%	42%	86%
Other/Mixed race	6%	8%	3%
Hispanic (any race)	4%	7%	4%

Sources: Wilder Research 2012 survey of homelessness and U.S. 2010 Census

Note: Column totals may be more than 100% because Hispanic ethnicity is asked independent of race.

Over two-thirds (70%) of homeless veterans had lived in Minnesota for more than five years. Over half (55%) of homeless veterans grew up in another state or country.

Over two-fifths (43%) of surveyed homeless veterans had never been married. Nearly two-fifths (38%) were divorced, 10 percent were separated, 4 percent were currently married, and 4 percent were widowed.

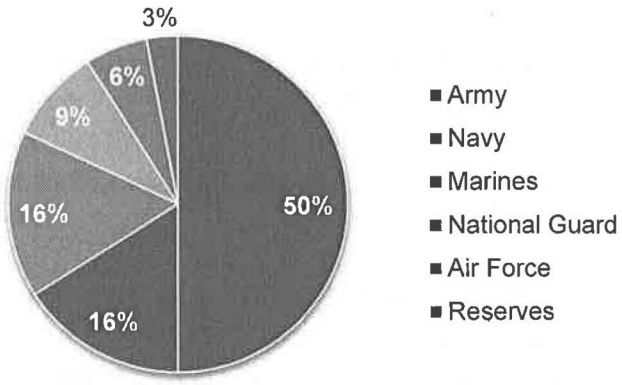
Ninety-six percent of homeless veterans had graduated from high school or completed a GED, and one half (50%) had some type of post-secondary education. For comparison, approximately nine of ten (92%), of adults in the general population have completed high school.[3]

Veteran status

On Thursday, October 25, 2012, the study found that 355 homeless adults in the Twin Cities area and 225 homeless adults in greater Minnesota had served in the U.S. military. This represents approximately one-tenth (9%) of the total homeless population and 17 percent of homeless men in Minnesota.

Half (50%) of the U.S. military veterans had served in the Army, 16 percent in the Navy, 16 percent in the Marine Corps, 9 percent in the National Guard, 6 percent in the Air Force, and 3 percent in the Reserves.

8. Branch of U.S. military in which homeless veterans served



[3] *2011 American Community Survey.* Minnesota Selected Social Characteristics in United States. [Statistics from Data file] Retrieved September 11, 2012 from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Over two-fifths (46%) of homeless military veterans began their service between October 1980 and March 2003. One percent began their service before August 1964; about one-fifth (22%) began between August 1964 and May 1975; and about one-fifth (22%) began between June 1975 and September 1980. Ten percent began their service in April 2003 or later.

9. Dates homeless veterans entered U.S. military service

	Men (N=538)	Women (N=37	Total (N=575)
Prior to August 1964	1%	-	1%
August 1964 to May 1975	23%	-	22%
June 1975 to September 1980	23%	11%	22%
October 1980 to March 2003	45%	52%	46%
April 2003 or later	8%	38%	10%

One-quarter (26%) of homeless veterans reported serving in a combat zone. Ten percent served in a combat zone in Vietnam, 4 percent in the first Gulf War, and 8 percent in the current Iraq War or Afghanistan. Other conflicts, mentioned by about 1 percent each, included Lebanon/Beirut, Panama, Granada, Korea, and Serbia/Bosnia.

Two-thirds (67%) of homeless veterans reported that the length of their military service was more than two years; about one-fifth (21%) served between 181 days and two years.

Over two-thirds of homeless military veterans (70%) received an honorable discharge, and 13 percent received a General Discharge. Nearly half (47%) of homeless veterans reported service-related health problems, primarily mental health problems (44%) and hearing/ear problems (33%). Six percent reported that they have been diagnosed with a service-related head injury or traumatic brain injury.

About one-third (34%) of homeless military veterans reported that during the past 12 months they had contact with a County Veterans Service Officer; over one-quarter (28%) had attended a Project Homeless Connect event; and over one-quarter (27%) had attended a Veterans Stand Down event.

Over two-fifths (44%) of homeless veterans were currently using veterans' benefits. The benefits most frequently used were Veterans Administration Medical services (34%) and service-related compensation (19%). An additional 1 percent of veterans were not currently using veterans' benefits, but had used veterans' benefits in the previous 12 months.

Public assistance and service use

The services most commonly used by homeless veterans during the month of the survey (October) were:

- Food stamps (48%)
- Free clothing shelves (39%)
- Hot meal programs (37%)
- Transportation assistance (35%)
- State or federal veterans benefits (32%)
- Drop-in centers (31%)
- Food shelves (23%)
- Emergency room (21%)
- Free medical clinic (19%)

One-fifth (19%) of homeless veterans reported having lost public benefits during the 12 months preceding the study. Of those who lost benefits, the benefits most frequently lost were food stamps (68%), medical benefits (34%), and unemployment benefits (14%).

Seven percent of homeless veterans (5% of men and 45% of women) had received MFIP in the previous 12 months.

More than four-fifth (83%) of homeless veterans had medical coverage of some kind in October. Just over one-fifth (21%) of homeless veterans had received care in an emergency room in October, and more than two-fifths (42%) of homeless veterans reported receiving care in an emergency room in the previous six months

One-quarter (25%) of homeless veterans reported needing help applying or reapplying for services, particularly for medical benefits (29% of those needing help with applications), food stamps (29%), SSI (25%), and housing assistance (15%).

Employment

Over one-fifth (22%) of homeless veterans were employed; 9 percent were employed full-time. Two-thirds (67%) of employed homeless veterans reported that their job had lasted at least three months. Nearly half (48%) of employed homeless veterans reported that their jobs paid less than $10 per hour.

Of those veterans who were not employed, 13 percent reported they had been laid off, terminated, or had their job eliminated in the last six months. For nearly one-fifth (18%) of unemployed veterans, it had been less than six months since they had last held a steady job. Seventeen percent of unemployed veterans last had a job between six months and one year prior; 14 percent last had a job one to two years prior; 13 percent had last been employed two to three years prior; 6 percent had last been employed three to four years prior; and almost one-third (32%) reported that their last job had been more than four years prior.

10. Unemployed homeless veterans: length of time without a job

How long has it been since you last held a job?	Men (N=402)	Women (N=26)	Total (N=428)
Less than six months	17%	27%	18%
Six months to one year	18%	8%	17%
One to two years	14%	8%	14%
Two to three years	12%	27%	13%
Three to four years	6%	8%	6%
More than four years	33%	23%	32%

Nearly half (49%) of unemployed homeless veterans were looking for work. The most frequently mentioned barriers to employment were physical health problems (37%), mental health problems (18%), lack of transportation (17%), lack of job opportunities (14%), criminal background (14%), lack of housing (14%), and age (13%).

Income

Homeless veterans surveyed reported their main sources of income for the month of October had been from General Assistance (26%), steady employment (16%), Social Security Disability Insurance (SSDI) (10%), Supplemental Security Income (SSI) (7%), Social Security (7%), and day labor (7%).

When homeless veterans were asked about their total income for the month of October, 14 percent reported some income, but $100 or less; 23 percent reported incomes of $101 to $300; 6 percent reported incomes of $301 to $500; 17 percent reported incomes of $501 to $800; and 30 percent reported incomes over $800. Ten percent of respondents reported having no income in the month of October.

Overall, homeless male veterans had lower median incomes than homeless female veterans ($400 vs. $437). The median income for homeless male veterans in the Twin

Cities area was $280, compared to $412 for homeless female veterans. In greater Minnesota the median income for homeless male veterans was $641 compared to $600 for homeless female veterans

History of homelessness

For one-third (33%) of homeless veterans interviewed, this was their first experience of homelessness. Over one-quarter (28%) had been homeless two or three times in their lives, 17 percent had been homeless four to seven times, and over one-fifth (22%) had been homeless eight or more times. The average age at which veterans reported becoming homeless for the first time was 35; the median age was also 35.

Four percent of homeless veterans reported they had been homeless for more than a week but less than one month; 37 percent had been homeless for at least one month but less than one year; 32 percent had been homeless for at least one year but less than three years; 10 percent had been homeless for at least three years but less than five years; and 18 percent had been homeless for five years or longer.

11. Homeless veterans length of time without stable housing

	Men (N=537)	Women (N=38)	Total (N=576)
More than one week but less than one month	4%	3%	4%
At least one month but less than four months	13%	25%	14%
At least four months but less than 7 months	15%	11%	15%
At least 7 months but less than 12 months	9%	14%	9%
At least one year but less than three years	32%	28%	32%
At least three years but less than five years	10%	7%	10%
Five years or longer	18%	12%	18%

Sixty-three percent of homeless veterans met the Minnesota definition of long-term homelessness (they had been homeless for a year or longer, or four or more times in the previous four years). Nearly half (46%) of homeless veterans met the federal definition of chronic homelessness, which, in addition to the long-term criteria in the Minnesota definition, also requires the presence of at least one serious or chronic disability and a marital status of single.

Shelter use

Over three-quarters (77%) of homeless veterans reported having lived in an emergency shelter (68% in the previous two years). Three percent of homeless veterans reported having lived in a battered women's shelter (1% in the previous two years). Over two-fifths (42%) of homeless veterans reported having lived in a transitional housing program (37% in the previous two years). Twelve percent of homeless veterans lived in permanent supportive housing (9% in the previous two years). Overall, 91 percent of all homeless veterans surveyed had lived in a temporary or supportive shelter facility (emergency shelter, battered women's shelter, transitional housing, or permanent housing with supportive services); of those, 87 percent had done so in the previous two years. Very few veterans report living in any of these types of facilities as children.

About one-quarter (24%) of homeless veterans left a homeless service program in the previous 12 months. Of the 141 veterans who left a homeless service program, four-fifths (80%) last left an emergency shelter, 14 percent last left transitional housing, 6 percent last left permanent supportive housing, and 1 percent last left a battered women's shelter.

Over two-fifths (42%) Of the 141 veterans who left a homeless service program, reported that they had a stable place to live at the time they left the program. Almost one-third (31%) received help from the program in finding a stable place to live, and 26 percent were offered follow-up or aftercare services. Sixty-eight percent of the 19 homeless veterans who last left a transitional housing program reported having stable housing when they left. Thirty-eight percent of the 112 homeless veterans who last left an emergency shelter reported having stable housing when they left. Thirty-eight percent of the eight homeless veterans who last left a permanent supportive housing program reported having stable housing when they left.

Four percent of homeless veterans had been in their current temporary housing arrangements for less than one month. Over one-third (37%) had been in their current temporary housing for one month or more, but less than one year. Nearly three-fifths (59%) had been in their current temporary arrangement for more than one year.

Nearly one-fifth (19%) of homeless veterans had been unable to obtain shelter at least once in the previous three months. The last time that happened, they reported having slept in the following places:

- Outdoors (40%)
- Cars, abandoned buildings, or other enclosed spaces (21%)
- Another shelter (17%)

- With family or a friend (11%)
- A motel or other shelter with a voucher (7%)
- Hospital (2%)
- Jail (1%)

Over one-third (37%) of homeless veterans reported having stayed outdoors at least one night during the month of October. Twelve percent had spent one to seven nights outdoors, and one-quarter (25%) had spent eight or more nights outdoors. The average number of nights spent outdoors was six.

Nearly one-quarter (22%) of homeless veterans reported that they had doubled up in the month of the survey (October). Eleven percent had spent one to seven nights doubled up, and one-tenth (10%) had spent eight or more nights doubled up. The average number of nights spent doubled up in October was two.

Residential placements

With respect to prior residential placements, two-thirds (66%) of homeless veterans surveyed had lived in at least one type of residential facility or program. If correctional facilities are included, the percentage increases to 80 percent. Men and women veterans were about equally likely to have lived in some type of residential setting (66% vs. 65%).

Homeless veterans most often had lived in correctional facilities (56%), drug or alcohol treatment facilities (46%), halfway houses (30%), mental health facilities (25%), group homes (20%), or foster care (17%). There were gender differences in the type of placements. Men were more likely than women to have been in a correctional facility (59% vs. 23%); in a drug or alcohol treatment facility (47% vs. 35%); hallway house (31% vs. 19%); a mental health facility (25% vs. 21%); or in a group home (20% vs. 17%). Women were more likely than men to have been in foster care (28% vs. 16%).

Less than ten percent of homeless veterans surveyed had lived in an adoptive home (8%) or a residence for persons with physical disabilities (3%).

12. Have you ever lived in any of the following types of facilities or programs?

	Percentage responding "yes"		
	Men	**Women**	**Total**
Foster care	16%	28%	17%
Drug or alcohol treatment	47%	35%	46%
Residence for persons with physical disabilities	3%	-	3%
Halfway house	31%	19%	30%
Mental health facility	25%	21%	25%
Group home	20%	17%	20%
Adoptive home	8%	7%	8%
Any of the above placements	**66%**	**65%**	**66%**
Juvenile detention or facility	16%	6%	15%
County jail or workhouse	53%	21%	51%
State prison	23%	16%	23%
Federal prison	5%	3%	5%
Any correction facility or detention center	59%	23%	56%
Any of the above, including correction facility or detention center	**80%**	**74%**	**80%**

Migration to Minnesota

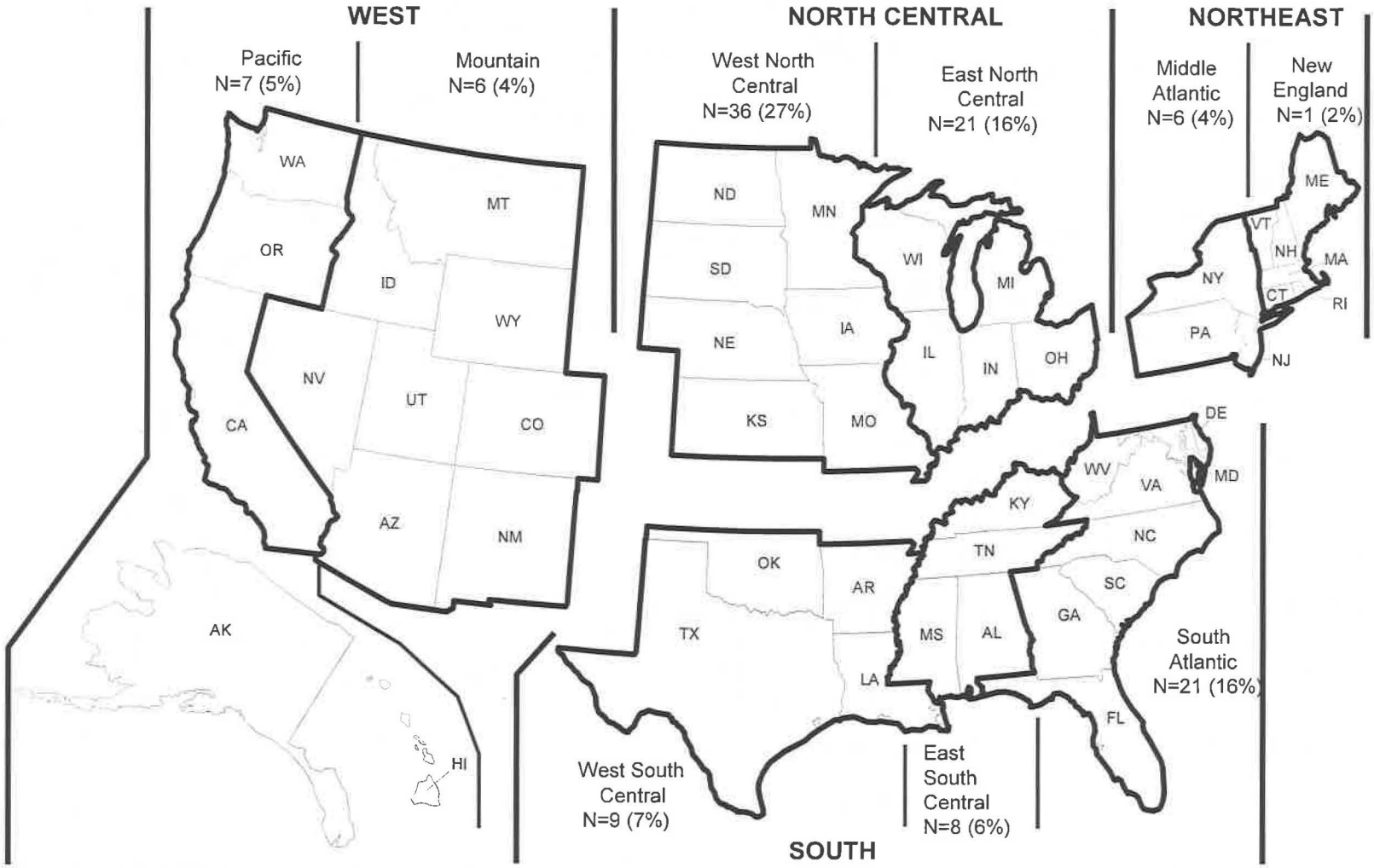
Homeless male veterans were more likely than homeless female veterans to have lived in Minnesota for less than one year (15% vs. 8%). Overall, 15 percent of homeless veterans had been in Minnesota for less than one year, 9 percent for one to two years, and 77 percent for longer than two years. Two-fifths (40%) of recent residents (two years or less) had previously lived in Minnesota.

Of the 134 homeless veterans who have lived in Minnesota two years or less, over one-fifth (27%) came from West North Central states; 16 percent from East North Central States; 16 percent from South Atlantic states; 7 percent from West South Central states; 6 percent from East South Central states; 5 percent from Pacific States; 4 percent from Mountain states; 4 percent from Middle Atlantic States; and 1 percent from New England states. In addition, 2 percent of homeless veterans came from other countries (Mexico and Thailand). Data on where homeless veterans lived before coming to Minnesota were missing for 12 percent of those interviewed. (See map on the next page.)

Additional maps on the following pages display the above information for the state as a whole, for those interviewed in greater Minnesota, and for those interviewed in the Twin Cities area.

13. All homeless veterans living in Minnesota two years or less: "Where did you live before coming to Minnesota?" N=134*

US Census Bureau geographic regions

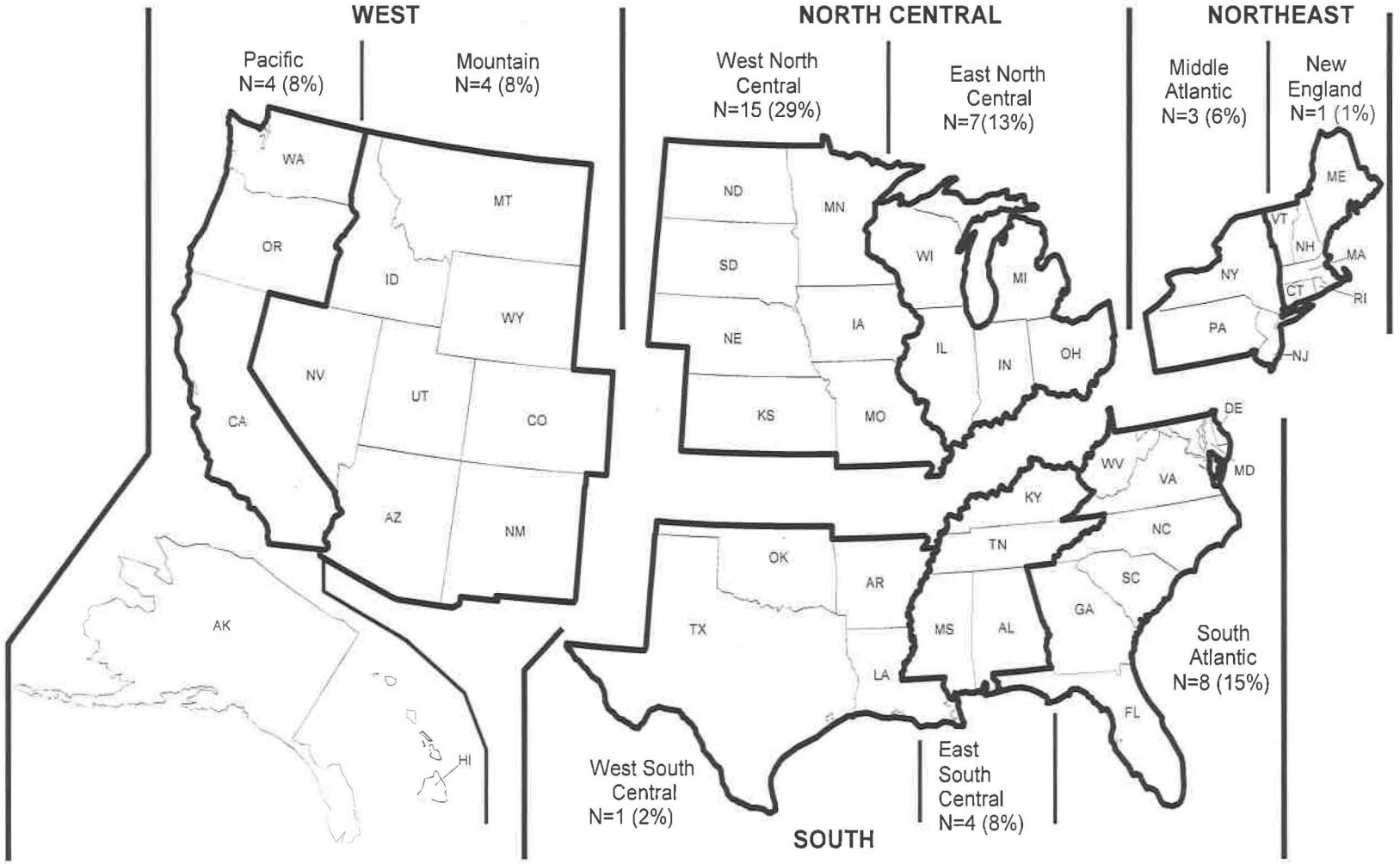


*Missing data N= 16 (12%)

Countries outside the United States N=3 (2%)

14. Greater Minnesota homeless veterans living in the state two years or less: "Where did you live before coming to Minnesota?" N=52*

US Census Bureau geographic regions

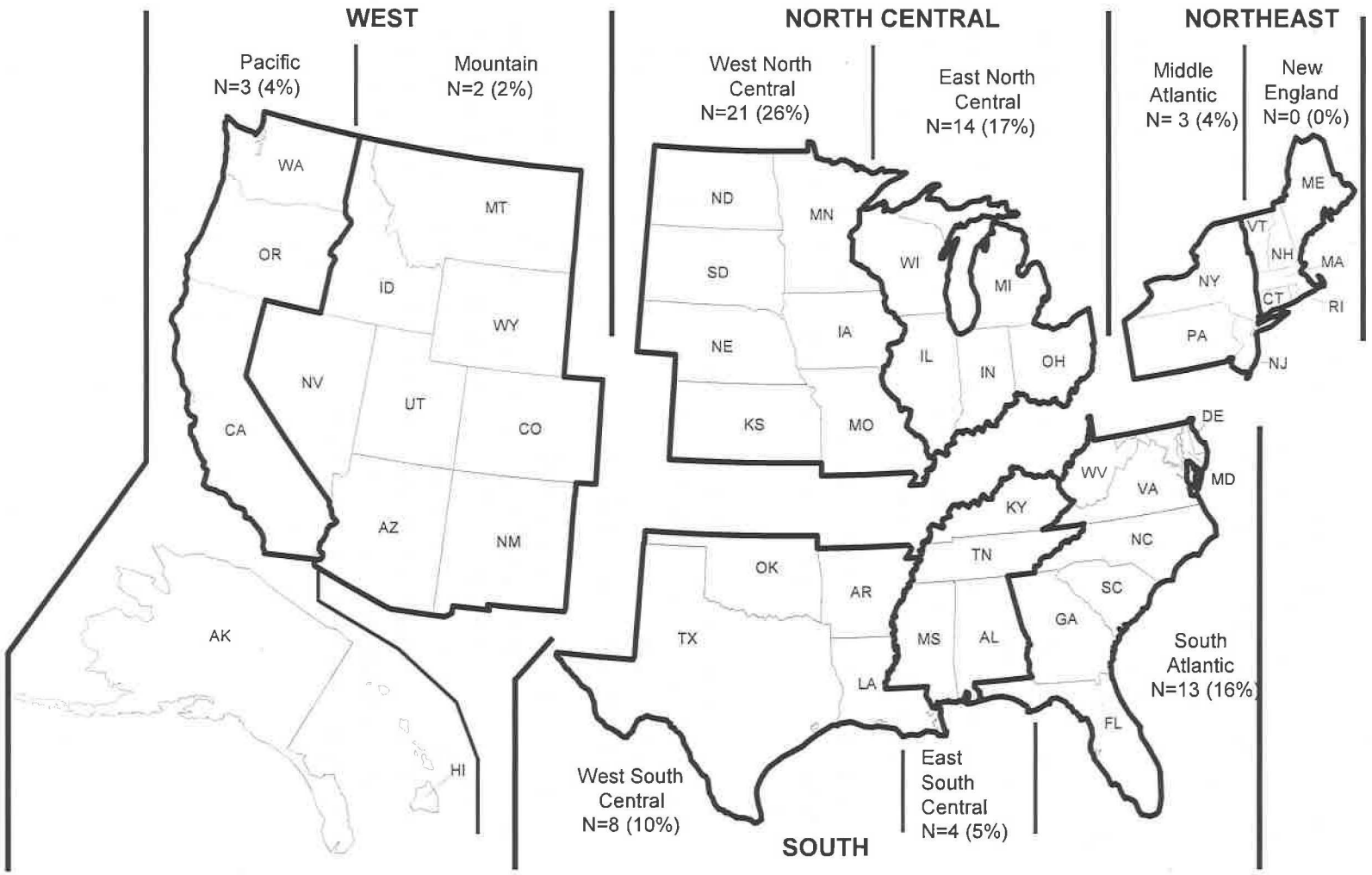


*Missing data: N=5 (10%)

Countries outside the United States: N=0

15. Twin Cities area homeless veterans living in Minnesota two years or less: "Where did you live before coming to Minnesota?" N=82*

US Census Bureau geographic regions



*Missing data N=11 (13%)

Countries outside the United States N=3 (4%)

Housing

Nearly three-fifths (59%) of homeless veterans reported that they had been without permanent housing for a year or longer. Over one-third (34%) of homeless veterans were on a waiting list for housing vouchers (Section 8) or housing that offers some type of financial assistance, and 15 percent of those veterans had been waiting for over a year. Sixteen percent of homeless veterans were unable to get on a waiting list, because the list was closed. Six percent of homeless veterans said they had received a housing voucher that they lost or could not use.

Over four-fifths (85%) of homeless veterans needed only an efficiency or one-bedroom apartment. One-quarter (25%) of homeless veterans were not able to pay any amount for rent. Eleven percent indicated they could pay $1 to $100 per month for rent; 9 percent could pay $101 to $200; 15 percent could pay $201 to $300; 11 percent could pay $301 to $400; 13 percent could pay $401 to $500; and 17 percent could pay more than $500 per month.

Two-thirds (68%) of homeless veterans indicated that their last regular or permanent housing was in Minnesota, 31 percent in another state, and less than 1 percent in another country.

The main reasons homeless veterans cited for leaving their last regular housing included loss of a job or reduction in work hours (38%); inability to afford the rent (37%); eviction (26%); their own drinking or drug problems (21%); problems getting along with the people they lived with (20%); or a breakup with their spouse or partner (20%).

Nearly one-third (30%) of women cited domestic violence as a reason for leaving their last housing. Men were more likely than women to cite the loss of a job (39% vs. 29%); inability to afford the rent (38% vs. 23%); eviction (26% vs. 16%); their own drinking or drug problems (22% vs. 9%); or entering treatment, jail or a residential program (15% vs. 3%). Women were more likely than men to cite a breakup with a spouse or partner (33% vs. 19%); substandard or unsafe housing (23% vs. 10%); or another household member's drinking or drug problem (13% vs. 10%).

16. Common reasons why homeless veterans left their last regular housing

Did you leave your last regular housing because...	Percentage responding "yes" Men (N-542)	Women (N-38)	Total (N=580)
You lost your job or had your hours cut	39%	29%	38%
You could not afford the rent or house payments	38%	23%	37%
You were evicted or your lease was not renewed	26%	16%	26%
A drinking or drug problem you had	22%	9%	21%
Breakup with your spouse or partner	19%	33%	20%
Problems getting along with other people you lived with	20%	27%	20%
You entered treatment, jail or a residential program	15%	3%	15%
You were living in substandard or unsafe housing	10%	23%	11%
A drinking or drug problem of another member of your household	10%	13%	10%
Abuse by someone you lived with	4%	30%	6%

Homeless veterans most often reported that the first place they stayed in when they lost their housing was with family or friends (38%); in an emergency shelter (24%); outdoors (11%); or in a van, bus station, or another public place (12%). Other places mentioned were a treatment program (2%); jail (2%); hotel or motel (6%); transitional housing (1%); rental housing (1%); hospital (2%); and halfway house (<1%). Homeless female veterans were more likely to stay with family or friends than homeless male veterans (53% vs. 37%).

The main reasons given by homeless veterans for currently being unable to obtain housing included lack of job or income (43%); no housing they could afford (21%); a criminal background (18%); credit problems (17%); no local rental history (7%); court eviction (6%); cost of application fees (6%); and alcohol or chemical use (5%).

Children of homeless veterans

Although over two-thirds (69%) of homeless female veterans and nearly one-quarter (23%) of homeless male veterans reported that they *had* children under the age of 18, the proportion caring for their children while homeless was substantially lower. Just under two-fifths (39%) of homeless female veterans and 1 percent of male veterans were accompanied by their children on the night of the survey. The parents accompanied by their children represented 5 percent of all homeless veterans surveyed. The average number of children with those parents was two, with an average age of seven years.

Of the 34 homeless veterans who had children with them, 26 percent reported being unable to obtain needed child care in the previous 12 months; 18 percent were unable to obtain needed dental care; 11 percent were unable to obtain needed physical health care; and 8 percent were unable to obtain needed mental health care. Six percent of the homeless veterans who had children with them reported that their children had to skip meals in the previous month. Over one-quarter (28%) of homeless veterans who had children with them reported having at least one child with emotional health problems, and 7 percent reported having at least one child with physical health problems that interfere with their daily life.

Twenty-three parents had school-age children with them. Of those parents, 42 percent reported that they have at least one child who has experienced bullying; 21 percent had at least one child with learning or school problems; 23 percent had at least one child who has repeated a grade in school; 18 percent had at least one child whose grades had dropped; and 15 percent had at least one child who has trouble going to school because of their current housing problems.

Chemical dependency

Over one-third (37%) of homeless veterans (37% of male veterans and 31% of female veterans) reported that they consider themselves to be alcoholic or chemically dependent. Over one-third (35%) of male veterans and one-fifth (20%) of female veterans had been admitted to a detox center at least once.

Nine percent of homeless veterans reported the need to see a health professional about alcohol or drug problems. Over one-quarter of male veterans (27%) and female veterans (28%) had been told by a doctor or nurse, within the previous two years, that they had chemical dependency problems.

Nearly half of male veterans (47%) and over one-third of female veterans (35%) reported that, at some time in their lives, they had lived in an alcohol or drug treatment facility. About one-fifth (19%) of male veterans and nearly one-quarter (23%) of female veterans had been in residential drug treatment programs in the previous two years.

Forty-four percent of male veterans and 34 percent of female veterans had received outpatient drug or alcohol treatment at some time in their lives. Thirteen percent of male veterans and 8 percent of female veterans received outpatient drug or alcohol treatment in the previous two years.

Physical health

Over half (54%) of homeless veterans reported they had at least one chronic medical condition (high blood pressure, asthma, other chronic lung or respiratory problems, chronic heart or circulatory problems, diabetes, hepatitis, HIV/AIDS, and/or tuberculosis). Of those, three-quarters (75%) reported receiving care for each reported condition in the previous 12 months.

Half (49%) of homeless veterans said they needed to see a dentist about tooth or gum problems, and over two-fifths (43%) said they needed to see a doctor for a physical health problem. One-sixth (16%) of homeless veterans reported they were not taking prescribed medication. Over two-fifths (42%) of homeless veterans had used emergency room services during the previous six months.

Over four-fifths (83%) of homeless veterans reported that they had medical coverage in October. Of those who reported having medical coverage, 34 percent had Medical Assistance; 30 percent had VAMC benefits; 11 percent had MinnesotaCare; 9 percent had Medicare; 6 percent had General Assistance Medical Care; 5 percent had Medicare plus another type of insurance; 5 percent did not specify the type of medical coverage they had; and 2 percent had employer-sponsored insurance. Over one-quarter (26%) of homeless veterans reported they had problems getting needed medical care, primarily because of a lack of money or insurance.

17. Type of medical insurance reported by homeless veterans who had some kind of coverage in October

	Percentage of those with coverage
Medical Assistance	34%
VAMC benefits	30%
MinnesotaCare	11%
Medicare	9%
General Assistance Medical Care (GAMC)	6%
Medicare plus another type of insurance	5%
Type of coverage not specified	5%
Employer-sponsored health insurance	2%

Over three-quarters (78%) of homeless veterans reported that they had a regular place to go for medical care. Of these, over two-fifths (43%) reported that they received medical care at a clinic that requires insurance or fees; 39 percent received care at the VA Medical Center; 7 percent received care at a free clinic; 5 percent received care at an emergency room; 2 percent received care at a medical center (not specified if these centers require fees or insurance); percent received care at a medical clinic (not specified if these clinics require fees or insurance), and 1 percent received care at a hospital. Two percent did not name any type of medical facility;

Mental health

Mental illness was a significant problem for nearly three-fifths (57%) of the homeless veterans interviewed in 2012. Half (50%) of homeless veterans had been told by a doctor or nurse (within the previous two years) that they had schizophrenia, manic depression, some other type of delusional disorder, major depression, antisocial personality disorder, or post-traumatic stress disorder. Forty percent of homeless veterans surveyed had received outpatient mental health services, and 14 percent had lived in a facility for persons with mental health problems within the previous two years. Over one-third (36%) of homeless veterans said they needed to see a doctor about a mental or emotional health problem.

18. Mental health characteristics of homeless veterans

	Percentage with characteristics		
	Men (N=542)	Women (N=38)	Total (N=580)
Schizophrenia	9%	-	8%
Paranoid or delusional disorder, other than schizophrenia	7%	3%	7%
Manic episodes or manic depression, also called bipolar disorder	20%	35%	21%
Major depression	34%	61%	36%
Antisocial personality, obsessive-compulsive personality, or another severe emotional disorder	16%	27%	17%
Post-traumatic stress disorder	24%	59%	27%
Any mental health diagnosis above	**48%**	**82%**	**50%**
Alcohol abuse disorder	23%	25%	23%
Drug abuse disorder	13%	20%	14%
Any chemical dependency diagnosis above	**27%**	**28%**	**27%**
Dual diagnosis (chemical dependency and mental illness)	17%	25%	18%

Serious or chronic disability

As described previously, half (50%) of homeless veterans had serious mental health problems (indicated by recent diagnosis or treatment), 27 percent had a diagnosed alcohol or drug abuse disorder, and over half (54%) had a chronic physical health condition.

According to many homeless veterans interviewed, physical, mental, or other health conditions limited the amount or kind of work they could do (54%), limited their daily activities (14%), or interfered with memory or daily decision-making (32%).

Pooling all of the above, nearly nine in ten (87%) homeless veterans reported having at least one serious or chronic disability (mental illness, substance abuse disorder, chronic medical condition, cognitive impairment, or other condition that limits work or activities of daily living).

Another concern is the fact that traumatic brain injury, which is reported by about one in three homeless veterans, is sometimes difficult to detect, and the symptoms may mimic those of post-traumatic stress disorder. While survivors may appear normal, they often have diminished memory, act in irrational ways, display episodes of rage, have difficulty concentrating, and generally have diminished capacity to maintain family relationships. Any of these elements, left untreated, can increase the likelihood of homelessness for new veterans.

One-third (33%) of homeless veterans in the Wilder study had a history that suggests likely traumatic brain injury. That is, they received a serious head injury, followed by the development of problems with headaches, concentration or memory, understanding, excessive worry, sleeping, or getting along with people.

Thirteen percent of homeless veterans report being told by a doctor or nurse in the previous two years that they have a traumatic brain injury. Six percent of homeless veterans report being diagnosed with a service-related head injury or traumatic brain injury.

Abuse and victimization

A history of childhood mistreatment was not uncommon for respondents in the survey. About one-third (34%) of homeless male veterans and 45 percent of homeless female veterans indicated that they were physically mistreated as children, and 18 percent of men and 30 percent of women reported sexual mistreatment as children. Thirteen percent of men and 37 percent of women indicated that, as children, their parents neglected to provide food, shelter, or medical care, or left them unsupervised for long periods of time when they were too young to be left on their own. Over one-third (36%) of homeless male veterans and nearly half (49%) of homeless female veterans were either physically

or sexually mistreated as children. If individuals reporting neglect as children were added, 38 percent of men and 59 percent of women reported mistreatment as children.

19. Childhood mistreatment reported by homeless veterans

	Men (N=542)	Women (N=38)	Total (N=580)
Physically abused as a child or youth	34%	45%	35%
Sexually abused as a child or youth	18%	30%	18%
Neglected as a child or youth (not provided food, shelter, or medical care, or left unsupervised for long periods of time)	13%	37%	15%
Any of the above experiences as a child	**38%**	**59%**	**40%**
Either physically or sexually abused as a child	**36%**	**49%**	**37%**

Eleven percent of homeless veterans interviewed (11% of men and 19% of women) reported being sexual with someone only for the purpose of getting shelter, clothing, food, and other things. About one-fifth (21%) of homeless male veterans and 52 percent of homeless female veterans reported staying in an abusive situation because they did not have other housing options. Eight percent of homeless male veterans and over one-third (35%) of homeless female veterans reported being in a personal relationship in the previous year with someone who hit them, slapped them, pushed them around, or threatened to do so. Nearly one-third (30%) of women veterans reported they were homeless, at least in part, because they were fleeing abuse.

The overall experience of homelessness can be a risky one, especially for women. Nearly one-sixth (15%) of homeless female veterans had been approached to work in the sex industry. Fourteen percent (14% of men and 20% of women) of homeless veterans reported having been physically or sexually attacked or beaten since becoming homeless. Eight percent of homeless veterans (7% of men and 16% of women) reported having sought health care because of an injury or illness caused by violence in the previous year.

Homeless veterans data tables

Detail tables including the frequency distributions for all questions included in the survey, with breakdowns by geographic area (Twin Cities area vs. greater Minnesota), by gender (male vs. female), and by type of shelter arrangement (emergency shelter, transitional housing programs, informal shelter, and unsheltered locations) can be found on our website http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-Detailed-Data.aspx.[4]

The tables are organized by question. Within each question, the first data table displays the responses by the type of shelter arrangement and the second table displays the responses by the Twin Cities area, then by the greater Minnesota area, and then by the combined totals for the Twin Cities area and greater Minnesota.

Note that some tables are conditional. For example, Table 174 reports the number of respondents who have considered suicide. This question was asked of everyone. Table 175 reports information about suicide attempts, but this question was asked only of those who had considered suicide. Thus, the percentages reported in Table 175 total 100 percent of those who have considered suicide, not 100 percent of the entire sample.

Notes for interpreting the data tables

The tables contain weighted estimates. This means that the survey results have been statistically adjusted to reflect the actual populations residing in emergency shelters and transitional housing programs on the day of the survey. (We interviewed a sample, not every person in each shelter.)

For informal and unsheltered locations, the data are not weighted. We do not adjust the numbers to reflect the actual population, because we do not know the actual numbers of men, women, and children who were on the streets or in other non-shelter locations on the day of the survey.

You should use the percentages, not the frequencies, when interpreting these tables. Sample weighting, such as we have performed with these data, uses calculations that can result in "fractional" persons. When we use computer rounding to adjust for this, the numbers do not always add up exactly to the total for each category.

[4] Unsheltered arrangements include outside, abandoned buildings, vehicles, temporary paid, or exchange arrangements.

The total number of responses is different for each question, based on the number of valid responses to that question. Missing data (cases when a respondent did not answer a question) are not reported or included in the percentages.

Weighting techniques

The 2012 survey data were weighted to reflect the actual number of homeless persons as indicated by specific site counts of people in shelters in Minnesota on Thursday, October 25, 2012. Only sites from which there were completed interviews were used in the weighting. The actual number of homeless persons in non-sheltered locations cannot be accurately estimated, so these cases were given a weight of 1.0.

The weightings were calculated by a sample-balancing program available in the Princeton Statistical Program (P-Stat). This technique uses an iterative approximation to the least square adjustment of W.E. Deming (Statistical Adjustment of Data, New York: Wiley, 1943). This weighting procedure uses marginals (totals of control variables) to compute individual case weights. In order to obtain the highest possible accuracy, 5 sets of marginals were used.

These were:

- Individual sites
- Gender (male, female)
- Region (Twin Cities area and greater Minnesota)
- Shelter type (emergency, transitional)
- Shelter type within region by gender (all combinations of items 2, 3, and 4 above).

Weightings were used to estimate the characteristics of homeless veterans in Minnesota temporary housing programs on the night of the survey, based on the sample of interviews with adults in such programs. Statistical weightings could not be computed if interviews were not completed in a specific weighting category (e.g., region, shelter type, and gender).

The 2012 data tables can be found on our website: http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-Detailed-Data.aspx

APPENDIX I

Comparison of State Veterans Homes Eligibility

State	# of Homes	Eligibility
Alabama	4	Eligible wartime veterans, then peacetime veterans
Alaska	1	Qualifying veterans, 75% of the home for veterans, 25% open to the public, state-run nursing home run by the Dept. of Human Services
Arizona	2	Honorably separated veterans and their spouses
Arkansas	1	Spouses and Gold Star Parents can apply
California	8	Eligible veterans and their spouses
Colorado	5	Spouses, widows, and Gold Star parents
Connecticut	1	Eligible veterans with chronic medical conditions that require skilled nursing care or 24-hour assistance/supervision
Delaware	1	Eligible veterans residing in the state for three or more years that meet state standards for needing nursing home level of care
Florida	7	Eligible veterans
Georgia	2	Eligible veterans
Hawaii	1	Eligible veterans requiring skilled or long term nursing care. Spouses or Gold Star Parents accepted based on availability of space.
Idaho	3	Eligible resident veterans and their spouses eligible for skilled nursing care. Eligible veterans are eligible for domiciliary and residential care.
Illinois	5	Veterans wartime, then veterans peacetime, then spouses.
Indiana	1	Eligible veterans who have one day of wartime services and three years residency in the state, and their spouses
Iowa	1	Eligible veterans and spouses, and widows of eligible veterans
Kansas	2	Eligible veterans, spouses if space is available
Kentucky	3	Eligible resident veterans in need of nursing care
Louisiana	5	Limited to "Louisiana war veterans"
Maine	6	Eligible resident veterans or veterans residing in Maine at the time that they entered the U.S. Armed Forces. Spouses, widows, widowers, and Gold Star Parents accepted based on availability.
Maryland	1	Eligible veterans and eligible spouses
Massachusetts	2	Eligible veterans
Michigan	2	Eligible resident veterans with at least 90 days of active duty service who are considered unemployable. Parents, widows/widowers, and spouses or former spouses of eligible veterans.
Minnesota	5	Spouses of eligible veterans over 55 and who meet residency requirements
Mississippi	4	Resident veterans and spouses
Missouri	7	Eligible veterans requiring institutional health care services
Montana	2	Eligible veterans and spouses based on availability
Nebraska	4	Eligible resident active duty veterans disabled by service, age, or unable to earn a livelihood. Spouses, widows/widowers, Gold Star parents.
Nevada	1	Eligible resident veterans, spouses, Gold Star parents

State	# of Homes	Eligibility
New Hampshire	1	Eligible resident veterans with assets below $275,000 and one year residence in New Hampshire
New Jersey	3	Eligible active duty veterans and qualified National Guard/Reserve retirees, their spouses, widows/widowers. Must meet asset limit criteria. Preference given to individuals residing in Nevada for two years.
New Mexico	1	Eligible veterans and their spouses, Gold Star Parents. Preference given to New Mexico residents, but residency is not required.
New York	5	Eligible veterans and spouses
North Carolina	4	Eligible veterans
North Dakota	1	Eligible veterans and spouses, and widows of eligible veterans
Ohio	3	Eligible veterans
Oklahoma	7	Eligible veterans serving during World War I, World War II, the Korean conflict, Vietnam, or Persian Gulf Wars. Veterans must be disabled by age, disease, or other reasons.
Oregon	1	Eligible veterans, spouses or surviving spouses, Gold Star Parents in need of skilled or intermediate nursing home care. Residency is not a requirement.
Pennsylvania	6	Eligible resident veterans or spouses
Rhode Island	1	Eligible resident veterans who served 90 days or more during a foreign war or conflict
South Carolina	3	Eligible veterans and spouses
South Dakota	1	Eligible veterans and spouses, and widows of eligible veterans
Tennessee	3	Eligible veterans entitled to treatment from the VA. Spouses, widow/widowers, and Gold Star Parents on a space-available basis. Residency requirements met by individuals residing in Tennessee, born in the state, who entered the armed forces in Tennessee, or has immediate family member or legal guardian in state.
Texas	8	Veterans, spouses, and Gold Star Parents.
Utah	4	Eligible veterans and spouses, and widows of eligible veterans, Gold Star parents.
Vermont	1	Eligible veterans, spouses, and Gold Star Parents. Preference given to residents, but residency is not required.
Virginia	2	Eligible veterans. Must be Virginia resident or enter into the armed forces from Virginia
Washington	3	Eligible resident veterans, spouses, widows, or Gold Star Parents
West Virginia	1	Eligible resident active duty veterans with at least 12 consecutive months of service in the Armed Forces or reserves. Must be ambulatory and independent in all activities of daily living.
Wisconsin	3	Spouses and widows of eligible veterans
Wyoming	1	Eligible resident veterans, spouses, and their dependants. Qualified nonveterans, as space permits. Must be able to maintain activities of daily living and cannot be gainfully employed.

Prepared by Mary Mullen, House Research Department, November 2013

APPENDIX J

Minnesota Department of Veterans Affairs

October 2013
Select Committee on Veterans Housing

Minnesota Department of Veterans Affairs - Discussion Topics

- What We Do
- Waiting lists
- Mpls Campus Development
- Current Bed Count and New Veterans Homes Applications
- Cost of Care
- CMS Certification and Medicare/Medicaid Billing

Minnesota Department of Veterans Affairs – What We Do

- **What we do**

The Veterans Homes Division provides a continuum of long-term care for its Residents, with a strong emphasis on remembering and recognizing the service and sacrifices of all Veterans. The five State Veterans Homes in Minnesota, located in **Minneapolis, Hastings, Silver Bay, Luverne and Fergus Falls**, focus on providing the excellent care and services that Minnesotans expect for our state's military heroes. These five homes manage medical care on a 24/7 basis through a combination of skilled nursing care beds, domiciliary(board and care), rehabilitation, recreational therapy, work therapy and dementia programs and Adult Day Care.

Minnesota Department of Veterans Affairs – What We Do

Minneapolis

- Adult Day Center
- Domiciliary Care
- Skilled Nursing Care
- Central Pharmacy located on this campus for entire network

Hastings

- Domiciliary Care
- Vocational/Therapeutic Rehabilitation
- Wood Shop

Silver Bay, Fergus Falls and Luverne

- Skilled Nursing Care

Minnesota Department of Veterans Affairs – What We Do

Resident Characteristics for Skilled Nursing Care

- Male, Average age 78, WWII Veteran
- Top 3 Diagnosis:
  - Alzheimer's disease
  - Dementia w/behavioral disturbances
  - Organic brain syndrome (chronic)
- Multiple nursing home stays before admission to Veterans Homes

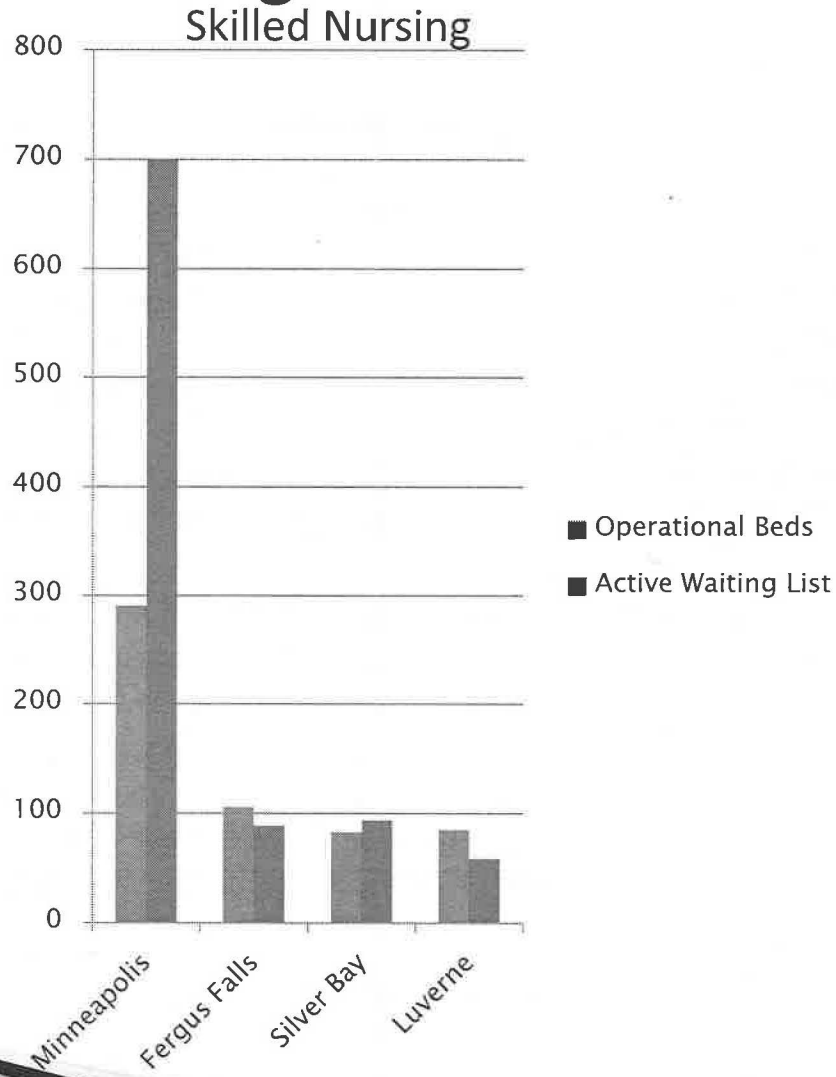
Resident Characteristics for Domiciliary Care

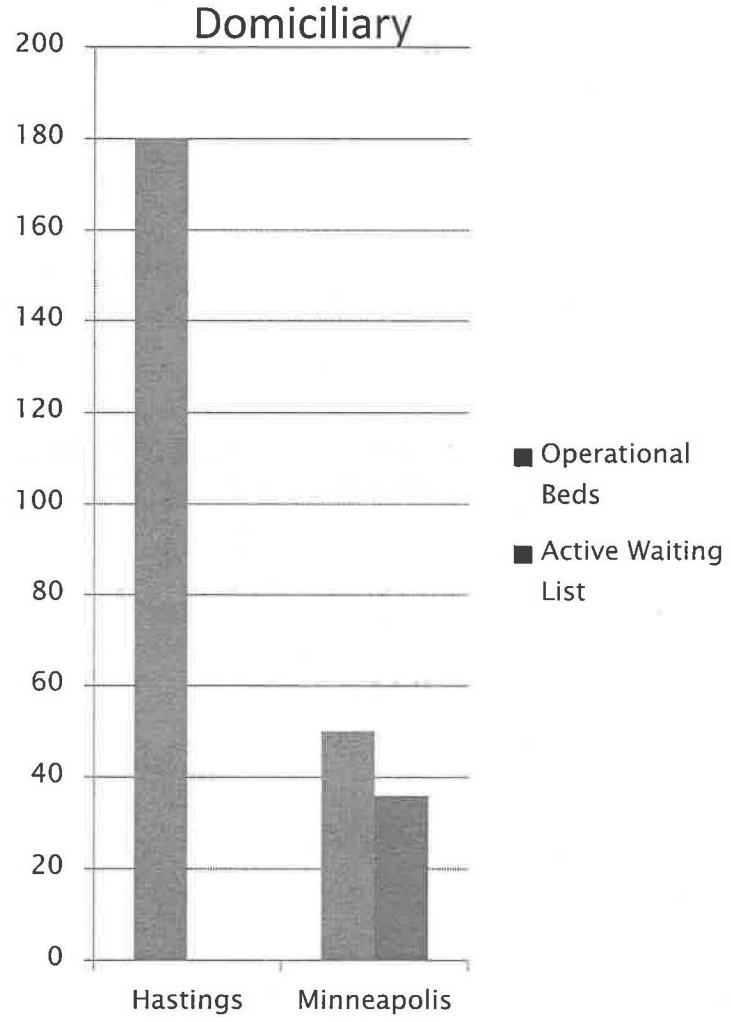
- Male, Average age 58, Vietnam Veteran
- Top 3 Diagnosis:
  - Hypertension
  - Diabetes
  - Cardiac disorders
- Additional Diagnosis:
  - Alcohol dependence syndrome
  - Schizophrenic disorders
  - Affective psychoses/depression

Resident Characteristics for Adult Day Center

- Male, Average age 81, WWII & Korean Veteran
- Top 3 Diagnosis:
  - Dementia
  - Alzheimer's Disease
  - Parkinson's Disease

Minnesota Department of Veterans Affairs - Waiting Lists

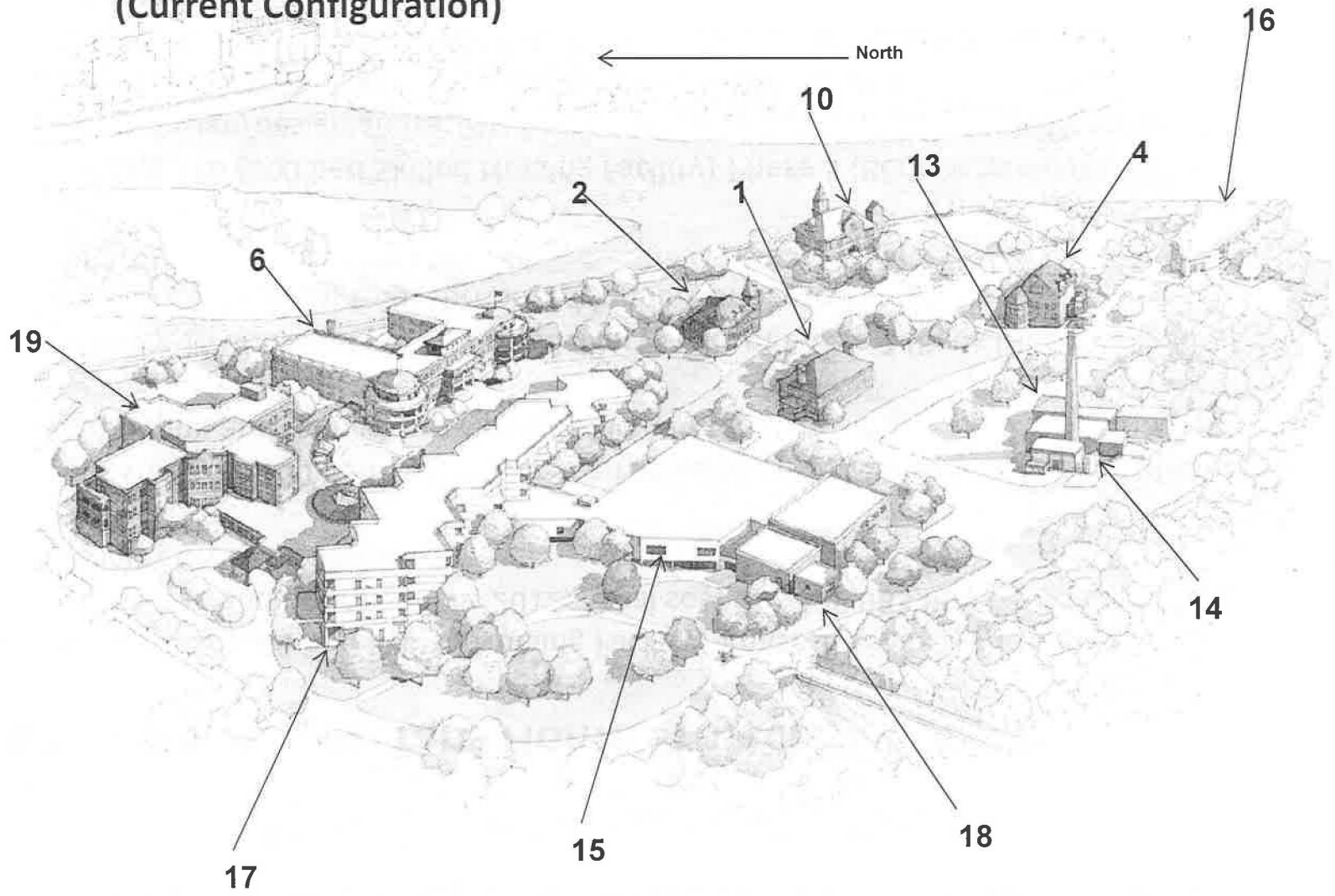




As of August, 2013

Minnesota Department of Veterans Affairs – Mpls Campus Development

(Current Configuration)



Minnesota Department of Veterans Affairs – Mpls Campus Development

Minneapolis Veterans Home Projects

- **Building 19 (100 bed Skilled Nursing Facility)-Phase 1** (Beds before: 0; after-100)
  Completed and occupied July, 2012; total cost was $28,983,000
  pending CMS certification

- **Building 17N (100 bed Skilled Nursing Facility)-Phase 2** (Beds before: 100; after-100)
  Demolition and rebuild; anticipated start Winter 2014

- **Building 16 Remodel (50 bed Domiciliary)-Part of Phase 2** (Beds before: 50; after-50)
  Occupied July 2013; total authorized funding of phase 2
  is $36,198,000

- **Building 17S (100 bed Skilled Nursing Facility)-Phase 3** (Beds before: 100; after-100)
  In pre-design/design phase; 2012 received $3,050,000 for design; 2013 received $18,935,000 state match; includes tunnel systems, campus utility connections and all other related campus infrastructure to tie phases; anticipated cost $54,100,000

- **Building 6** (No change in bed count – 91 beds)

Total: 441 (100 bed increase)

Minnesota Department of Veterans Affairs - Bed Count and New Homes Applications

Beds Currently Operated	
Hastings	180
Fergus Falls	101
Silver Bay	83
Luverne	85
Mpls B-19	100
Mpls B-16	50
Mpls B-6 (17N)	91
Mpls B-17S	100
Total	790

+

Applications for Beds	
Mpls B-17N	100
Mpls B-17S	100
Willmar	90
Montevideo	90
Bemidji	70
Brainerd	70
Total	520

= **1,310**

- 1,310 – 320 = 990 Operational Beds & Active Federal Applications
- Bed Cap for Minnesota = 1058 beds

Minnesota Department of Veterans Affairs – Cost of Care

- Finances of a Veterans Home
  - VA per diem
  - Resident maintenance charge
  - State general fund appropriation

Minnesota Department of Veterans Affairs – Definitions

- **VA per diem** – The approved daily rate established by the VA to reimburse state veterans homes for providing specified levels of care to eligible Veterans.
  - **"Full" per diem or prevailing rate** – The rate reimbursed to state veterans homes for providing care to eligible Veterans with a 70% or more service connected disability. Prevailing rate is based on Medicare Part A RUG IV rates for skilled nursing care facilities.
  - **"Regular" per diem** – The rate reimbursed to state veterans homes for providing care to eligible Veterans with no or less than 70% service connected disability.

Minnesota Department of Veterans Affairs – Definitions

- **Maintenance Charge** – Is determined according to each individual's ability to pay based on their individual assets, income and expenses.

- **Cost of Care** – The average daily rate for the entire facility to provide care to all residents.

Minnesota Department of Veterans Affairs – Cost of Care

Direct Care Costs	+	Indirect Costs	+	Vets homes admin and agency overhead	+	Drug costs	=	Cost of operating a MN State Veterans Home
Direct Care Costs	+	Indirect Costs	+	Drug costs	-	Medicare Part D reimbursements	=	Cost of Care

Resident w/ 70% or more service connected disability	Cost of Care	-	Full VA per diem	=	No cost to resident
Veteran resident	Cost of Care	-	Regular VA per diem	=	Resident responsible for maintenance charge, which is adjusted for income; general fund approp covers remainder
Non-veteran spouse resident	Cost of Care			=	Resident pays full cost of care, if high income. Otherwise, adjusted for income; general fund approp covers remainder

Minnesota Department of Veterans Affairs – Cost of Care - Spouses

Home	Avg # of spouses	Avg Mntc fee paid per month by spouses	Avg annual Mntc paid by spouses	Avg annual cost of care (COC)	Avg COC less avg mntc = avg state approp per spouse	Avg annual state appropr for spouses
Fergus Falls	12	$1,812	$21,744	$100,548	$78,804	$945,645
Luverne	11	$1,949	$23,388	$100,834	$77,446	$851,903
Silver Bay	9	$1,799	$21,588	$110,290	$88,702	$798,315
Mpls	29	$1,432	$17,184	$122,515	$105,331	$3,054,590
Hastings	NA	NA				
Total						$5,650,452

Minnesota Department of Veterans Affairs – Cost of Care - 70%ers

Home	Avg # of 70%ers	Prevailing Rate for 70%ers (Full Per Diem)	Avg Annual Prevailing Rate
Fergus Falls	8	$362.24	$132,217.60
Luverne	4	$362.24	$132,217.60
Silver Bay	3	$362.24	$132,217.60
Mpls	27	$424.41	$154,909.65
Hastings	NA	NA	

Questions

APPENDIX K

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

VA Medical Foster Home Fact Sheet

Medical Foster Home (MFH) is an alternative to nursing home in a personal home, for selected Veterans who are no longer able to safely live independently. MFH is a type of Community Residential Care (CRC) home chosen by Veterans with serious chronic disabling conditions that meet nursing home level of care need, but prefer a non-institutional setting for their long-term care. This Department of Veterans Affairs (VA) MFH program brings together a person who is willing to open their home and serve in the role of a strong family caregiver, the VA MFH Coordinator who manages the program, and a VA interdisciplinary home care team that provides care in the MFH to the Veteran and training to the MFH caregiver. The MFH is matched with the Veteran's physical, social, and emotional needs, including supervision and protection.

The MFH coordinator finds a caregiver in the community who is willing to take a Veteran into their home and provide 24-hour supervision as well as needed personal assistance. VA provides comprehensive primary care through the interdisciplinary home care team, and the Veteran pays the caregiver. The expectation is that this is a long-term commitment, where the Veteran may live for a few years, often for the remainder of his or her life. **The Veteran pays the caregiver** approximately $1500 to $3000 per month (average is $2,300) depending upon the care needs and situation.

The VA interdisciplinary home care team is an integral component of MFH, usually provided through either Home Based Primary Care (HBPC) or Spinal Cord Injury Home Care (SCI-HC). Staff from these programs makes home visits to provide home assessment, caregiver support and education, direct patient care, and oversight.

MFH follows CRC requirements for oversight, recruitment and inspection of these homes in which to place Veterans. When applicable/required in each state, any existing regulations and licensure for MFH may apply.

MFHs are generally distinguished from assisted living or other CRC homes in that, 1) the home is owned or rented by the MFH caregiver who lives in the MFH and provides personal care and supervision; 2) all Veterans in MFH meet nursing home level of care need; 3) there are no more than three residents receiving care in the MFH, including both Veterans and non-Veterans; and 4) MFH residents are enrolled in a VA interdisciplinary home care program. These factors facilitate matching suitable MFHs with the greater complexity of this subset of Veterans, achieving safe and therapeutic care in a small personal home.

The economics are advantageous to all. A Veteran choosing MFH pays for the MFH. The Veteran (both non-service connected and service connected) is assisted by maximizing Veterans Benefits and Social Security funds that the Veteran would receive regardless of living arrangement. The administrative costs for VA are about $10 per day, the cost of HBPC, medications and supplies averages less than $50 per day, and the Veteran pays about $80 per day for room, board and personal assistance. One-fourth of these Veterans are eligible for fully VA-paid nursing home care, yet they choose to spend their personal funds for MFH because they greatly prefer this type of care. MFH is a welcome alternative to nursing home placement that is safe, favorable to Veterans, economically advantageous to the VA facility, and contributes to community development. MFH provides an alternative to nursing home, in a personal home, at half the cost.

At this time MFH is operational at 99 VA medical centers in 45 states and territories, and growing to a total of 114 VA medical centers in 48 states and territories, with further expansion planned.

VA Facilities Operating or Developing the MFH Program

Albuquerque, NM
Amarillo, TX
Ann Arbor, MI
Arlington/Fort Worth, TX
Asheville, NC
Atlanta, GA
Augusta, GA
Augusta, ME
Baltimore, MD
Battle Creek, MI
Bay Pines, FL
Big Spring, TX
Biloxi, MS
Birmingham, AL
Black Hills, SD
Bonham, TX
Boise, ID
Boston, MA
Castle Point, NY
Charleston, SC
Charleston, WV
Cheyenne, WY
Chicago @ Hines, IL
Chillicothe, OH
Cincinnati, OH
Cleveland, OH
Coatesville, PA
Columbia, SC
Columbus, OH
Dallas, TX
Danville, IL
Dayton, OH
Denver, CO
Des Moines, IA
Dublin, GA
Durham, NC
East Orange, NJ
El Paso, TX
Fargo, ND
Fayetteville, AR
Fayetteville, NC
Fort Harrison, MT
Gainesville, FL
Grand Junction, CO
Guam @ Agana Heights
Hampton, VA
Hays, KS
Honolulu, HI
Hot Springs, AR
Houston, TX
Huntington, WV
Hutchinson, KS
Indianapolis, IN
Jackson, MS
Jacksonville, FL
Kansas City, MO
Kerrville, TX
Lakeland, FL
Lebanon, PA
Lexington, KY
Little Rock, AR
Louisville, KY
Manchester, NH
Martinsburg, WV
Memphis, TN
Miami, FL
Minneapolis, MN
Murfreesboro, TN
Muskogee, OK
Nashville, TN
New Orleans, LA
New Port Richie, FL
Northern Indiana, IN
NY Harbor, NY
Oakwood, GA
Oklahoma City, OK
Omaha, NE
Orlando, FL
Palo Alto, CA
Pensacola, FL
Philadelphia, PA
Phoenix, AZ
Ponce Mayaguez, PR
Port Charlotte, FL
Portland, ME
Portland, OR
Prescott, AZ
Richmond, VA
Rutherfordton, NC
Sacramento, CA
Salem, VA
Salisbury, NC
Salt Lake City, UT
San Antonio, TX
San Juan, PR
Scottsburg, IN
Seattle, WA
Sheridan, WY
Sioux Falls, SD
St Louis @ Jefferson Barracks, MO
St Louis @ North Country, MO
St Lucie, FL
Tampa, FL
Temple/Waco, TX
Tomah, WI
Tucson, AZ
Tuscaloosa, AL
Tuskegee, AL
Walla Walla, WA
Washington, DC
West Palm Beach, FL
Wichita, KS

Revised 9/30/13

APPENDIX L

STATE OF MINNESOTA DEPARTMENT OF VETERANS AFFAIRS
MINNESOTA VETERANS HOME - MINNEAPOLIS
★ ★ ★
5101 Minnehaha Avenue South . Minneapolis, Minnesota 55417
Resident Accounts: 612-548-5718 . Cashier: 612-548-5717 . Billing: 612-548-5773 . Benefits: 612-548-5723

Financial Office
Frequently Asked Questions

Welcome to the Minnesota Veterans Home Minneapolis. This guide is provided to help you better understand the financial benefits and obligations of you or your family member living in a Minnesota Veterans Home.

Quick Reference Guide:

Minnesota Rule 9050

The Minnesota Veterans Home (Home) is required to follow Minnesota Statutes Chapter 198 and Minnesota Rules Chapter 9050 for decisions regarding financial and medical policies and procedures. According to this Rule:

> *"This chapter applies to all veterans homes facilities presently owned or controlled by the state of Minnesota and operated by the commissioner of veterans affairs, to all facilities that are or may be developed in the future for ownership or control by the state of Minnesota and operation by the commissioner of veterans affairs, and to all individuals residing in or conducting activities in the facilities unless otherwise indicated."*

The Minnesota Rule 9050 that we are required to follow is extremely complicated and its effect can vary greatly depending on each Resident and their individual situation. In the following pages we will outline some of the common questions and circumstances that occur here; but due to the very different situations of each Resident there is no way we can cover everything. We encourage you to contact us right away with any questions that you may have about your individual situation relating to these or any other financial questions now or at any time during your stay here.

While we are here to help and to try to provide you with the best knowledge of our Rules we can, we are not able to give legal or financial advice. We greatly encourage you to contact an Elder Law Attorney to help give you further guidance to be able to make informed decisions that are best for the Resident and/or their spouse/dependents.

Sincerely,

The Financial Office
of the
The Minnesota Veterans Home Minneapolis

MAINTENANCE ACCOUNT

Maintenance Rate:

Q. How are my maintenance charges determined?

A. The maintenance charge is determined according to each individual's ability to pay based on their individual assets, income, and expenses. This information is then used to calculate each Resident's monthly maintenance rate.

Q. How is the maintenance rate calculated?

A. The maintenance rate is calculated according to Minnesota Rule 9050.0755:

The chargeable income of an applicant or resident is as follows:

A. total the person's gross income according to part 9050.0710;

B. subtract from the total gross income the applicable expenses or deductions in parts 9050.0720 to 9050.0750 to get the net income;

C. subtract from net income $90 for personal needs;

D. multiply item C by 0.05 and deduct this amount from item C; and

E. the sum calculated in item D is the applicant's or resident's monthly chargeable income

For Example:

Calculation	Example
(A) Resident's Monthly Income	$1,000.00
(B) (Resident's Monthly Expenses)	($ 100.00)
(C) ($90)	($ 90.00)
$xxx.xx	$ 810.00
(D) x 95%	x 95%
Maintenance Rate	$ 769.50

Using the example, the Resident has $1,000 in income and $100 in expenses. The Resident gets to keep $90 for personal a needs as well as an additional 5% after all expenses are deducted for personal needs (p.8); so the total personal needs of this Resident is $130.50 ($90 plus $40.50). What is left after all deductions and personal needs is the monthly maintenance rate, in this case $769.50.

Q. Once my maintenance rate has been determined upon admission will it ever change?

A. There are many reasons your maintenance rate could change including:

- When there has been a substantial change (p.16) to income or expenses
- Annually with the financial packet when your income and expenses are reviewed.
- If the Resident transfers between nursing and domiciliary care for over thirty days

Q. What is the Full Cost of Care rate, and how is that determined?

A. The Full Cost of Care rate is calculated based on the average daily rate for the entire facility to provide care to all Residents. This rate is determined annually and is effective July1st of each year.

Q. Why am I paying the Full Cost of Care rate if my maintenance charge is supposed to be determined on my income and expenses?

A. According to Minnesota Rule 9050.0560:

The amount that a resident must pay, or have paid on the resident's behalf, as a maintenance charge must be determined as specified in items A and B.

A. If an applicant's or residents net worth exceeds $3,000, the person's maintenance charge must be the full cost of care for the applicant's or resident's level of care less the United States Department of Veterans Affairs per diem reimbursement, when applicable, until the applicant's or resident's net worth is reduced to $3,000.

B. If the applicant's or resident's net worth is less than $3,000, the applicant's or resident's income must be considered in calculating the person's maintenance charge. The person's monthly maintenance charge is the person's total chargeable income, up to the full cost of care. The person's chargeable income must be calculated according to part 9050.0755.

Residents are allowed to have up to $3,000 in total assets (p.5) and those who have over $3,000 in assets must pay the full cost of care rate until their assets are spent down below the allowable limit. Once the assets are spent down the Resident will then be charged based on their actual income and expenses.

Billings:

Q. When will I get the monthly maintenance bill and when is it due?

A. The bills are mailed out by the 10th of the month, so you should see them in your mail box the middle of the month depending on your mail service. The maintenance bill is due by the last day of the month in which it is received.

Q. How can I pay the maintenance bill?

A. There are several ways to make the monthly maintenance payment:

- mail the payment to the address listed on the bill to the attention of the cashier
- pay the cashier directly at the cahier window when you are visiting your loved one
- if the cashier is not open during your visit you can place the payment directly in the drop box by the cashier window.

Q. Why do I see an additional charge on my maintenance account called "finance charges?"

A. The maintenance account is to be paid in full by the last day of the month in which the charge occurred. All accounts that are past due are assessed a finance charge, currently 6%.

ASSETS

Q. When a Resident has many assets are all of them considered when determining the allowable $3,000 asset limit?

A. No. Some assets are not considered available when calculating the maintenance rate, they are:

- Homestead, only if occupied by a spouse or dependent child
- Value of property owned jointly with another person that the applicant or Resident cannot liquidate or cash in through the exercise of his or her rights
- Real or personal property intended or needed to produce income (ie: rental, farm property, equipment, etc.)
- Prepaid burial accounts, up to $8,500
- One motor vehicle
- Household goods, clothes, furniture, and similar personal property

Remember only the Resident's assets are considered when calculating the maintenance rate. If you would like more information on excluded assets please refer to Rule 9050.0600 which describes the assets to be excluded in further detail; you can find this online (p.20) or request a copy from the Home.

Q. The Resident has a life insurance policy, is this considered an asset?

A. It depends on the type of life insurance the Resident has. Only the cash value of a life insurance policy is considered an asset of the Resident when the Resident is the owner of the policy. Please contact your insurance company to see if this policy needs to be considered an asset of the Resident putting them over the $3,000 asset limit.

Transfers:

Q. I transferred some assets of the Resident's to myself and my children, is that okay?

A. According to Rule 9050.0650 there are two kinds of asset transfers; incorrect and permitted.

Permitted transfers are defined as:

Transfer or sale of property by or on behalf of an applicant or resident is permitted if the transfer or sale:

A .takes place more than 12 months before the person's admission to a facility operated by the commissioner of veterans affairs;

B. is to the applicant's or resident's spouse or dependent child or children before the person's admission to a facility operated by the commissioner of veterans affairs; or
C. is for market value with the proceeds available for payment toward the person's cost of care.

Incorrect Transfers are defined as:

A transfer or sale of property for less than market value within 12 months before admission or during the resident's stay in a facility operated by the commissioner of veterans affairs, unless permitted under subpart 2, is presumed to be for the purpose of establishing or maintaining eligibility for admission to or continued residence in a facility operated by the commissioner of veterans affairs or to avoid payment of the maintenance charge, unless the person furnishes convincing evidence to show that the transfer was for another purpose. Convincing evidence must include evidence that the person had no health or economic reasons to believe that nursing home or boarding care would be needed. Upon discovery of an incorrect transfer, a retroactive adjustment must be made in the maintenance charge assessed to the resident. If the property that was incorrectly transferred was in the resident's name, the maintenance charge must be increased to the full cost of care until the facility has been paid the value of the property that was incorrectly transferred in addition to the maintenance charge that would have otherwise been received. If the property that was incorrectly transferred was in the spouse's name only, the spousal allowance must be eliminated for the number of months which, when multiplied by the amount of the spousal allowance that would have been granted but for the incorrect transfer, equals the value of the property that was incorrectly transferred.

Your asset transfer may be okay depending on when the transfer took place or how the transfer was done:

Correct Transfers:

- occurred one day before admission to the spouse or dependent child(ren)
- occurred 12 months before admission with no restrictions.
- the asset was sold for market value and the proceeds are considered an available asset for the Resident

Incorrect Transfers:

- the asset was transferred or sold for less than market value within 12 months of admission or at any time after the date of admit

According to the rules if there has been an incorrect transfer of assets the Home will still consider the value of those assets as part of the Resident's asset limit (p.5). If there has been an incorrect transfer of assets the facility must do a retroactive adjustment to the maintenance charge to the full cost of care until the facility has been paid the value of the incorrectly transferred property in addition to the maintenance charge that would have otherwise been received.

Please consult the Home before any transfers of assets occur to be given more specific information relating to your situation so that you can make an informed decision.

EXPENSES

Q. What expenses are allowed for the Resident when determining the maintenance rate?

A. Expenses allowed for the Resident, to deduct from income, are expenses related to:

- employment expenses, including FICA and tax withholding
- medical debts not relating to long term care, incurred *prior* to admission
- court ordered child support payments
- health insurance – including Medicare
- if the Resident that has a spouse or dependent child(ren) that qualify for a spousal allowance this is also deducted.

If you would like more information on expenses please refer to Rule 9050.0720 which describes the expenses allowed in further detail; you can find this online (p.20) or request a copy from the Home.

Q. The Resident would like to use his money for something that is not an allowable expense according to your rules. For example they would like to have cable in their room, can you allow this expense?

A. No, that is not an allowable expense. However, the Resident is able to use their personal needs money (p.8) for anything they would like, including expenses that we are not able to allow for in the maintenance rate determination.

Q. The Resident's expenses have changed, should I notify the home now or wait until the next financial packet?

A. You should notify the Home as soon as you learn of a change in expenses for the Resident. This will affect the maintenance rate, personal needs amount, and/or spousal allowance.

INCOME

Q. What income is considered when determining the maintenance rate?

A. According to Rule 9050.0040, Subp 54, income is defined as:

> *"Income" means cash or in-kind benefits, whether earned or unearned, received by or available to an individual and not established as property under part 9050.0700, subpart 1, and any other income not otherwise defined as earned or unearned income.*

Income will differ according to each Resident, but some examples of income are: social security, VA benefits, pensions, IRAs, annuities, interest, dividends, long term care insurance, supplemental social security, public assistance, etc. If you would like more information on income please refer to Rules 9050.0700, 9050.0710 and 9050.0550 which describes income in further detail; you can find this online (p.20) or request a copy from the Home.

Q. The Resident's income has changed; do I need to notify the Home?

A. You should notify the Home as soon as you learn of a change in income for the Resident. A change in income will affect both the maintenance rate and personal needs amount of the Resident.

Q. What is the "personal needs" money for the Resident?

A. The monthly personal needs money for each Resident is different; all Residents are given $90 and then an additional 5% after all expenses have been taken out of their income. The Resident is allowed to use this money for any expenses not allowed in the maintenance rate calculation, ie: cell phone, storage units, etc. The Resident can also use this money for any other things they want, ie: going out to dinner, charitable donations, personal shopping, gifts, etc.

SPOUSAL ALLOWANCE

Q. What is a spousal allowance?

A. According to Rule 9050.0400, Subp 106a, spousal allowance is:

> *"Spousal allowance" means the amount necessary to meet the basic needs of the dependent spouse or household that is deducted from the resident's gross monthly income.*

According to the Rules, spousal allowance is the amount of the Resident's income the spouse needs to be able to meet their monthly expenses. Not all spouses will qualify for a spousal allowance, it will depend the income and expenses of both the Resident and the spouse.

Q. I am not sure if I qualify for spousal allowance, how is it calculated?

A. Spousal allowance is calculated according to Rule 9050.0750:

Calculation	Example
Spouse's Monthly Income	$1,200.00
(Spouse's Monthly Expenses)	($1,600.00)
Spousal Allowance	$ 400.00

Using the example, the spouse has a monthly income of $1,200 but allowable expenses of $1,600. This spouse needs $400.00 from the Resident's income to meet their monthly expenses. If the spouse would have more income than expenses then that spouse would not qualify for a spousal allowance.

This amount, $400 in the example, is then deducted from the Resident's maintenance rate calculation (p.2) as an allowable expense of spousal allowance. The spousal allowance is paid from the Resident's monthly income and can be no more than the amount the Resident receives each month, even if spousal expenses are higher. If you would like more information on spousal allowance please refer to Rule 9050.0750 which describes this in further detail; you can find this online (p.20) or request a copy from the Home.

Q. I am not sure if spousal allowance is right for me, can you give further clarification on how spousal allowance will affect me as the spouse?

A. Deciding on whether or not to receive a spousal allowance is a big decision. Some spouses do not have the assets to be able to support themselves, so they have no choice but to receive a spousal allowance to be able to meet their monthly obligations.

For those spouses that have enough assets to be able to support themselves, the decision to receive a spousal allowance is a much bigger decision. You need to understand the following about spousal allowance:

- You must maintain your assets; you are not able to spend your assets freely. The assets that you have when the Resident enters the Home must be maintained year after year. If they have been spent, receipts will need to be provided showing that the asset was spent on an allowable expense according to our Rules.
- You will need to submit proof all of your assets, income and expenses each year with the financial packet (p.20).
- You are not able to freely sell or transfer your assets to others.
- Lump sums (p.17) of money that you receive will be used in your spousal allowance calculation and change the allowance for that month. The most common example would be a tax refund; your tax refund is considered income for yourself for the month received and would be owed to the Home.
- You need to make sure you understand the Rules, especially Rule 9050.0750, because you are expected to follow those rules when making financial decisions. Any Rules you do not understand you should contact the financial office right away before you make a financial decision as you will be held accountable for all decisions made.

The financial office can let you know if you qualify for spousal allowance according to Rule 9050.0750. It is then up to you to decide if it is right for you and your situation.

Income:

Q. What income is considered when determining the spousal allowance?

A. Income will differ according to each spouse, but some examples of income are: income from a job, social security, VA benefits, pensions, IRAs, annuities, interest, dividends, long term care insurance, supplemental social security, public assistance, capital gains, etc. If you would like more information on the income used for spousal allowance please refer to Rules 9050.0750 and 9050.0710 which describes this in further detail; you can find this online (p.20) or request a copy from the Home.

Q. I am getting interest from stock and savings accounts, why do you consider this income even though I am leaving it in my account?

A. Any income earned or unearned is considered income and available to you according to our Rule 9050.0040, Subp 54 (P.8). It is your choice on whether or not you want to spend that income or reinvest it, by leaving it in your account.

Q. My monthly income has changed, or I have received a lump sum, real estate or other property, should I notify the Home right away or wait until the next financial packet?

A. You should notify the Home as soon as you learn of a change in income when you are receiving a spousal allowance. This will affect the maintenance rate and your spousal allowance.

Q. I am considering a reverse mortgage or possibly a refinance of my Home, who should I tell?

A. This would be considered either a (p.17) lump sum payment or income according to our Rules and could impact your spouse's monthly maintenance charge and/or your monthly spousal allowance. Please contact us right away so that we can let you know how this would impact you or your spouse so that you can make an informed decision.

Expenses:

Q. What expenses are used when determining my spousal allowance?

A. According to Rule 9050.0750 allowable spouse/dependent expenses are:

A. expenses related to the homestead as follows:

(1) monthly rent, mortgage, or home equity loan payments, except that home equity loans obtained after the date of a resident's admission must be related to expenses of the homestead or other basic needs for which a deduction is requested;

(2) costs of supporting a dependent child or children residing with the spouse. Allowances for education of the child beyond high school or the equivalent of high school must not be considered. Student loans must not be considered as an allowance expense. If there is a dispute over whether or not an item is an education expense, the administrator shall make a final determination on the issue;

(3) real estate taxes;

(4) homeowner's or renter's insurance;

(5) home maintenance and repair costs in a reasonable amount. Allowances are provided for home maintenance to keep the homestead presentable and in good

working order. Allowances are not provided for improvements such as adding space or remodeling, except as necessary for physical access for the spouse or dependent;

(6)association fees for townhouses, condominiums, or similar arrangements;

(7)electric and gas charges;

(8)water and sewer charges;

(9)solid waste removal charges; and

(10)telephone costs;

B.transportation costs, including costs of public transportation and costs of acquiring and maintaining a privately owned motor vehicle;

C.food;

D.clothing;

E.medical insurance for the spouse and the applicant's or resident's dependent child or children residing with the spouse and long-term care insurance premiums for the spouse if the policy was purchased at least 12 months before the resident's initial admission date;

F.medical expense payments, except for expenses related to long-term care treatment. For the purposes of this item, long-term care expense includes expenses incurred for nursing homes, hospice care, home health care, foster care, adult day care, or similar nonacute care;

G.personal needs of the spouse or dependent child or children;

H.payments for documented consumer debts incurred before the resident's admission to a facility operated by the commissioner of veterans affairs for which the spouse is legally responsible. The payments may be limited to the minimum monthly payment due; and

I.support payments actually paid by the spouse to a former spouse or dependents who do not reside with the spouse.

If you would like more information on the expenses used for spousal allowance please refer to Rules 9050.0750 which describes this in further detail; you can find this online (p.20) or request a copy from the Home.

Q. I have some expenses that I do not see listed in Rule 9050.0750, for example my cell phone bill, how am I supposed to pay for this?

A. The only expenses we can allow for the spousal allowance calculation are the expenses listed in Rule 9050.0750. If you have other expenses then you may use your set monthly personal needs (p.8) expense to cover those.

Q. My monthly expenses have changed and I am receiving a spousal allowance, should I notify the Home now or wait until the next financial packet?

A. You should notify the Home as soon as you learn of a change in expenses for; for example paying off your mortgage or purchasing a new vehicle. This will affect the maintenance rate and/or spousal allowance.

Q. My needs have changed and I will be moving to an Assisted Living Community, will I still be able to get a spousal allowance?

A. Yes, but all of your monthly expenses may not be allowed. You will need to get an invoice from the assisted living facility and submit it to the Minnesota Veterans Home – Minneapolis for review. The invoice must show a clear break down of the charges incurred by the Spouse at this facility, because only the rent portion of the monthly charges will be allowed. If the facility includes food, medical services, utilities, etc., these items will need to be itemized, either by day or by month, because they may not be allowable expenses according to Rule 9050.0750. Also, if you will no longer be living in the Homestead, it may not longer be exempt and it may affect your spousal allowance and/or the Resident's maintenance charge.

Q. What types of expenses are included in my monthly allowable household expenses?

A. This allowable expense is calculated by the actual receipts for your minor home repairs and the upkeep needed to maintain the quality of your home. It also includes services such as lawn mowing or snow removal. Keep all receipts during the year and submit them with your financial packet (p.17) for determination for the following year's expense.

Assets:

Q. I am the spouse of a Resident and I receive a spousal allowance. I would like to give each of my three children $5,000 for Christmas this year, is that okay?

A. No. This is considered gifting, or incorrect transfer (p.5), and is not allowed while receiving a spousal allowance. You are not allowed to give large amounts of assets to anyone, except the Resident.

Q. I took money from my savings account and invested it in some new stock, do I need to tell the Home even if I reinvested all of the money?

A. Yes. You will need to provide us with documentation of the moving of any excluded asset, even if you are placing it in another excluded asset account. If you take money from an excluded asset and spend it, you may lose your spousal allowance because that amount would be considered available to you that month to use towards your living expenses.

Moving:

Q. I am thinking about moving out of my home, should I let the financial office know?

A. According to Rule 9050.0600, Subp. 2. A1:

The facility financial staff shall exclude the homestead of an applicant or resident from consideration as a resource according to the provisions in subitems 1-4. (1) The spouse of an applicant or resident or the dependent child or children of the applicant or resident, if any, must occupy the homestead.

Yes. This rule is saying that once the spouse/dependent no longer lives in the home, the home is no longer considered an exempt property, making it an available asset. This may potentially have a huge impact on your spouse's maintenance rate or your spousal allowance, depending on whose name the house is in. You should contact the financial office as soon as you are thinking about moving from your home to see how it will impact you and your spouse. If you would like more information on real property please refer to Rules 9050.0600 which describes this in further detail; you can find this online (p.20) or request a copy from the Home.

Q. I am going to sell my home, will this affect my spouse or me?

A. According to Rule 9050.0600, Subp. 2. A4:

When real property that has been used as a home by an applicant or resident, the spouse of an applicant or resident, or the dependent child or children of an applicant or resident is sold, the facility financial staff shall treat the proceeds from that sale as excluded property for a period of two years if the person intends to reinvest them in another home and maintains those proceeds, unused for other purposes, in a separate account. If the property is held jointly, any earnings that accrue on the sales proceeds before reinvestment or any excess proceeds not used for reinvestment must be treated as joint income or property and divided according to subpart 1, item A.

Yes. This rule is saying that if you sell your home and reinvest *all* proceeds in your new homestead, within two years, the proceeds will not have an impact on either you or your spouse. But, if you sell your home and move into an apartment, assisted living facility, with family, or any place that you are not purchasing, and do not intend to purchase a new home within two years, then the proceeds are treated as an available asset or income. This may potentially have a huge impact on your spouse's maintenance rate or your spousal allowance, depending on whose name the house is in. You should

contact the financial office as soon as you are thinking about moving from your home to see how it will impact you and your spouse. If you would like more information on real property please refer to Rules 9050.0600 which describes this in further detail; you can find this online (p.20) or request a copy from the Home.

Q. What will happen with any proceeds from the sale of my home if I choose not to purchase a new home?

A. The proceeds from the sale of a home are very complicated and can affect both the maintenance rate of the Resident and/or the spousal allowance in a major way. If the home is owned by both the Resident and the spouse, the proceeds are split and considered a lump sum income (p.17) for both. If the home is owned only by the spouse the proceeds are considered a lump sum income for the spouse only. Depending on your financial situation this may either raise the maintenance rate of the Resident to the full cost of care, eliminate the spousal allowance completely, or both.

Q. What if I own other Real Property, lake cabin, farm, timber property?

A. If the property is rented out, producing income or used for farming or some other business, it is excluded. If not, its value is considered an available resource and would affect your spousal allowance and/or the Resident's maintenance charge.

Financial Changes:

Q. If I open or close any financial accounts does the Home need to know?

A. Yes. If a financial account of any kind is closed please send in the closing statement along with the documentation of where the monies from that account went to. If a new financial account is opened please send in the account opening statement.

MAINTENANCE ADJUSTMENTS

Q. What is a maintenance adjustment?

A. A maintenance adjustment is done when there is a substantial change in income or expenses for the Resident and/or spouse *only* if they are allowed a spousal allowance expense. When a maintenance adjustment is done you will see it as a credit on the maintenance account for the month in which it was received.

Q. What is the legal definition of a substantial change?

A. According to Minnesota Rule 9050.0560, Subp 1, a substantial change is:

> *For purposes of the subpart, a "substantial change" in financial status means a change that increases the person's net worth above the $3,000 limit or a plus or minus ten percent change in the person's total monthly expenses or income.*

Expenses that constitute a substantial change include a major vehicle expense, major medical or dental expenses that are not covered by insurance, or a major appliance failure that requires repair or replacement. Any income can be a substantial change.

Q. Can you provide further clarification of what expenses may be considered a substantial change?

A. *Major Vehicle Expense* – Car repairs due to an accident must first be submitted to the insurance company and then the bill sent into us for the adjustment. The adjustment can only be made on the amount the insurance company would not pay (deductible). Major repairs made to the car must have a bill that includes a clear explanation of the work done and why that work was needed from the repair service.

Major Medical and/or Dental Expense – These are expenses not covered by insurance, the medical/dental bill first must be submitted to insurance and then sent into us for an adjustment. An explanation of necessity should be sent in with the adjustment request.

Major Home Repair – Any repairs done to the home due to storm damage, accident, or any other non cosmetic circumstance must be submitted to the homeowner's insurance first. Then, the difference (deductible) or other costs not covered may be submitted to us for an adjustment. A detailed explanation from the contractor of the work performed and why that work was needed should be sent in with the adjustment request. Cosmetic work is the responsibility of the homeowner and does not qualify for any adjustment.

Major Appliance Failure – A repairman must be called and must document that the appliance is un-repairable or the cost of repair is more than a new appliance for the adjustment to be considered. If repaired, a bill and explanation of the repair done must be submitted by the repairman with the

adjustment request. If a new appliance is bought, a receipt for the new appliance as well as documentation from the repairman must be sent into us.

Q. What do I do if I have a substantial change?

A. You need to contact the business office within ten (10) days of when you became aware of the major expense or income occurring. You should keep all of your receipts or paid invoices and proof of insurance claims to send into us.

Q. What do I do with my receipts that are not considered a substantial change?

A. If your receipts do not total more than 10% of your monthly expenses, keep those receipts in a safe place and you will submit them to us with your annual financial packet (p.20) for the following year. We will use these receipts to calculate your monthly allowable household expenses.

Q. What is the legal definition of a lump sum payment?

A. According to Rule 9050.0040, Subp 68, a lump sum payment is:

> *"Lump sum" means nonrecurring income received at one time. Examples include windfalls, debt repayment, payments from the sale of property, income or property tax refunds, and payments of accrued benefits, gifts, and inheritances.*

When you receive a lump sum payment it will change the monthly maintenance rate. This is because we use the amount received as income; so we need to recalculate your spousal allowance to reflect this additional income for the month. This new spousal allowance is then used to recalculate the monthly maintenance rate. When a lump sum income is received the monthly maintenance rate goes up.

Q. I just received an income or property tax refund, is this considered a substantial change?

A. All income and property tax refunds are considered "lump sum" payments and will be considered a substantial change. This will increase your monthly maintenance charge for the month it was received in because it is considered income, thus raising your income for that month. Income tax withholding and estimated tax payments are deducted each month, so if you receive a refund, we must add that back in.

TRUST ACCOUNT

Q. What is a trust account?

A. The trust account is like a personal bank account for the Resident here at the Home. The Resident can do both deposit and withdrawal transactions made through the cashier to their account.

Q. How do I know what the balance is in the Resident Trust account?

A. A trust account statement is mailed out each month with the monthly maintenance statement. It will show the deposits and withdrawals done in that month along with the current balance.

Q. The Resident is out of money in their trust account, how do I get more money in it?

A. If you notice the balance is low, or zero, when looking at the monthly trust account statement you can send in a trust deposit at any time. It is the same process as when you make the monthly maintenance payments. You can mail in a check or bring it into the cashier. *Please put "trust account" in the memo of the check,* so the cashier knows it is for the trust account and not the maintenance account.

Q. I am worried that if I put money in the trust account the Resident will spend it all in one day, is there anything I can do to prevent that?

A. Yes. While this is not a problem with all Residents, it is with some. If you are worried that the Resident will spend money too quickly you can put a restriction on their account. Each restriction is different and this is made according to that Resident's needs. It can be set by either the financially responsible party, the POA, guardian, conservator, social worker, etc. If this is something you think is needed please contact the cashier to complete the trust restriction form.

Q. I would like to use the barber services, but I am concerned that if I give the Resident cash for the barber it may get lost, are there any other options for payment?

A. Residents are able to pay for their barber services directly to the barber with cash or check. They also have the option to have the payment for services taken directly out of their trust account, provided they have enough funds in their account at the time of service. They will just have to sign for the service and it will be automatically taken out of their trust account.

BENEFITS

Q. I do not have any benefits right now, can I still be admitted to the Home?

A. According to Rule 9050.0770:

> *An applicant or resident or legal representative, if any, must apply for the maximum of every benefit for which the applicant or resident may be eligible that will increase the income of the applicant or resident. The staff of the facility operated by the commissioner of veterans affairs shall provide an applicant or resident or legal representative information about possible available benefits or programs of assistance and assistance in making application for those benefits.*

Yes. According to our rules all Residents need to apply for any and all benefits available to them while they are a Resident at the Home. No veteran will be turned away due to their benefit status.

Q. The benefits available are very confusing; do you have someone that can help with those?

A. Yes. We have a Veterans Claim Representative here at the Home to help assist the Residents and their families apply for and get the benefits available to them. Remember, benefits can change along with the changing status of a Resident, so check annually to see if the Resident is qualified for additional benefits.

Q. I got a letter in the mail from the VA and I am not sure what it means, should I let the Home know about this letter?

A. Yes. We do not always get the same correspondence as you do, so always let the Home know any time you receive a letter from anyone you are receiving benefits from. This could be very important, especially if your benefits are changing resulting in a change in income.

Q. I got a letter from the VA stating that the Resident will be now receiving an additional benefit resulting in a retro payment. Will this affect the Maintenance rate?

A. Yes, in two ways. First, the increase in benefits will increase the Resident's income resulting in a substantial change (p.16), thus increase the monthly maintenance rate. Second, the retro payment will result in an adjustment to the Resident's maintenance account for the time at the Home that coincides with the retro payment. As a general rule you can assume 95% of the retro payment will be added to the Resident's account through this adjustment.

INSURANCE/MEDICARE

Q. The Veteran has private insurance and to save money we want to cancel it because he will be able to go to the VA Medical Center, is this okay?

A. We recommend keeping your private medical insurance to cover any hospital stays that occur at places other than the VA Medical Center. These potential costs will not be an allowable deduction for the Resident while they are staying at the Home.

Q. The Resident does not have Medicare, is it necessary to enroll in Medicare?

A. According to Rule 9050.0770 (p.19) all Residents are required to apply for all benefits available to them, including Medicare coverage. If you need help enrolling or have questions regarding Medicare please consult your social worker.

Q. How does Medicare help the Home?

A. The Home is able to bill Medicare Part D for some of the prescriptions of the Residents. This enables the Home get funds from the Prescription Drug Plans thus helping to keep the monthly maintenance costs lower for the Residents.

Q. What if the Medicare/insurance status changes?

A. If you make or have changes to your Medicare or insurance coverage please let the Home know right away. If you are paying a premium, which is an allowable expense (p.7), this may result in a change to the maintenance rate. We also need to know so that we do not continue billing the company if they are no longer covering the Resident.

GENERAL QUESTIONS

Q. Can I have my income checks sent directly to the Home instead of having them go into my bank account and mailing in a check?

A. Yes. You can have all of the Resident's income checks sent to the Home. Once the checks are sent here there are several options available to the Resident on how they want their checks handled. We can directly deposit the check into the trust account or we can also make the monthly maintenance payment for them, so they do not have to worry about late payments. Please contact the Finance Office for the forms to change the VA and Social Security check to come directly to the Home, if you choose.

Q. How often will I have to complete a financial packet?

A. A financial packet needs to be completed every year in January for each Resident being charged based on income and expenses; regardless of the admit date of the Resident. The packet is mailed out right before the first of the new year and is due by February 28th of that year.

Q. What happens if a financial packet is not completed for the Resident?

A. If a financial packet is not completed each year it is considered lack of financial disclosure and the Resident will be placed at the current Full Cost of Care rate until the financial packet is completed. The Resident can be issued an Involuntary Discharge if the account is not paid in full each month while at this higher rate.

Q. Where can I find a copy of the Minnesota Rules mentioned above?

A. The Minnesota Administrative Rules Chapter 9050 can be found online at www.revisor.mn.gov/rules. Once at the website, scroll down the rules until you find the one you need or put the rules number in on the left side under: Retrieve by Number. If you would like a paper copy of the Rules contact the Finance Office.

Q. What is an Ombudsman and how can they help the Resident?

A. The Minnesota Board on Aging offers a program using an Ombudsman as an advocate for adults needing or receiving long term care. The Minnesota Veterans Home has a specific Ombudsman assigned to its Residents to help with various issues; including financial issues. You can contact the local office at (651) 431-2555 to find out the Ombudsman for the Home or ask your social worker.

Who should I contact?

Cashier: 612-548-5717

Call the cashier for questions relating to:

- Payments to the Maintenance account
- Trust account balance
- Trust account restrictions

Resident Accounts: 612-548-5718

Call Resident Accounts for questions relating to:

- Change of income or expenses
- Submitting maintenance adjustments
- Change in assets
- Maintenance calculation questions
- Spousal allowance questions
- Copies of financial forms

Billing: 612-548-5773

Call billing for any questions relating to:

- Maintenance charges
- Late Payments
- Account transaction questions

Veterans Claim Representative: 612-548-5723

Call Benefits for any questions relating to:

- Looking into benefit options available to you
- Current benefits or changes to your benefits
- Help with VA benefit forms

MINNESOTA VETERANS HOME – MINNEAPOLIS

5101 Minnehaha Avenue South

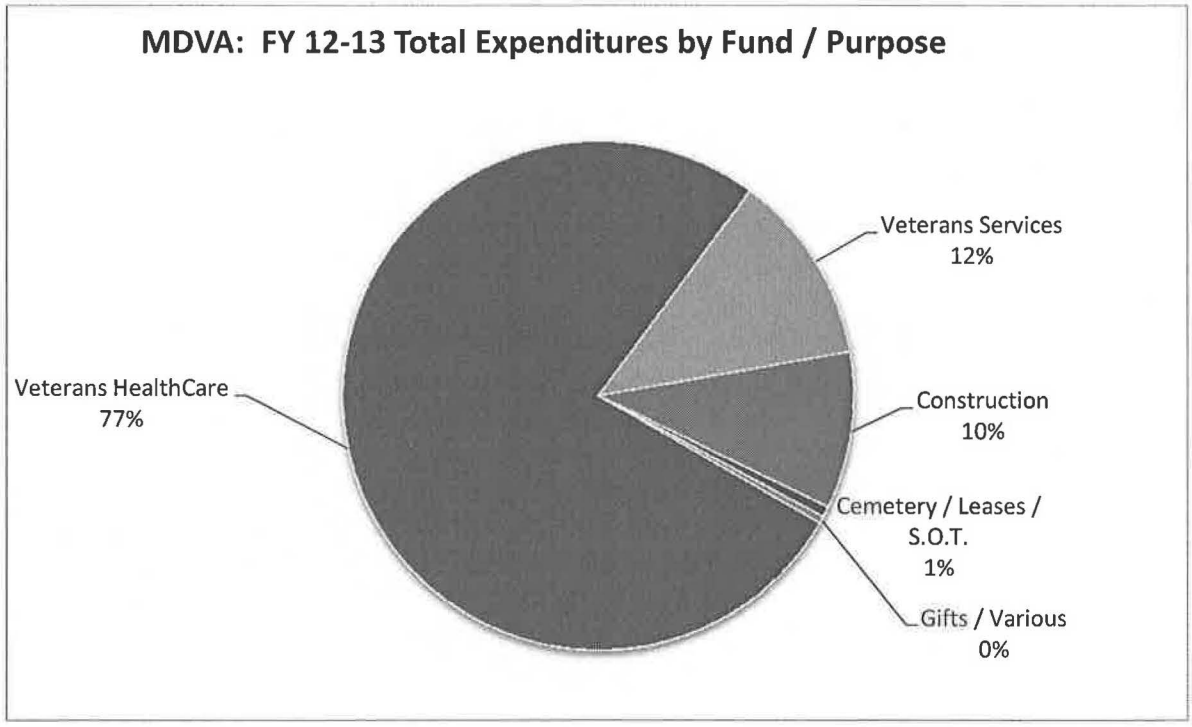
Minneapolis, Mn 55417

APPENDIX M

MN Veterans Homes: Funding Summary
(prepared by House Fiscal Staff)

The total expenditures from all funds[1] for the Minnesota Department of Veterans Affairs (MDVA) were $210.4 million in FY 2012-13.

MDAV has 2 programs: Veterans Services, and Veterans Health Care. The 5 state Veterans Homes comprise the Veterans Health Care program. All other services - including federal claims assistance, the MN GI bill, CVSO grants, state cemetery operations and many other activities are part of the Veterans Services program. Central administrative costs are allocated to each of these 2 programs.



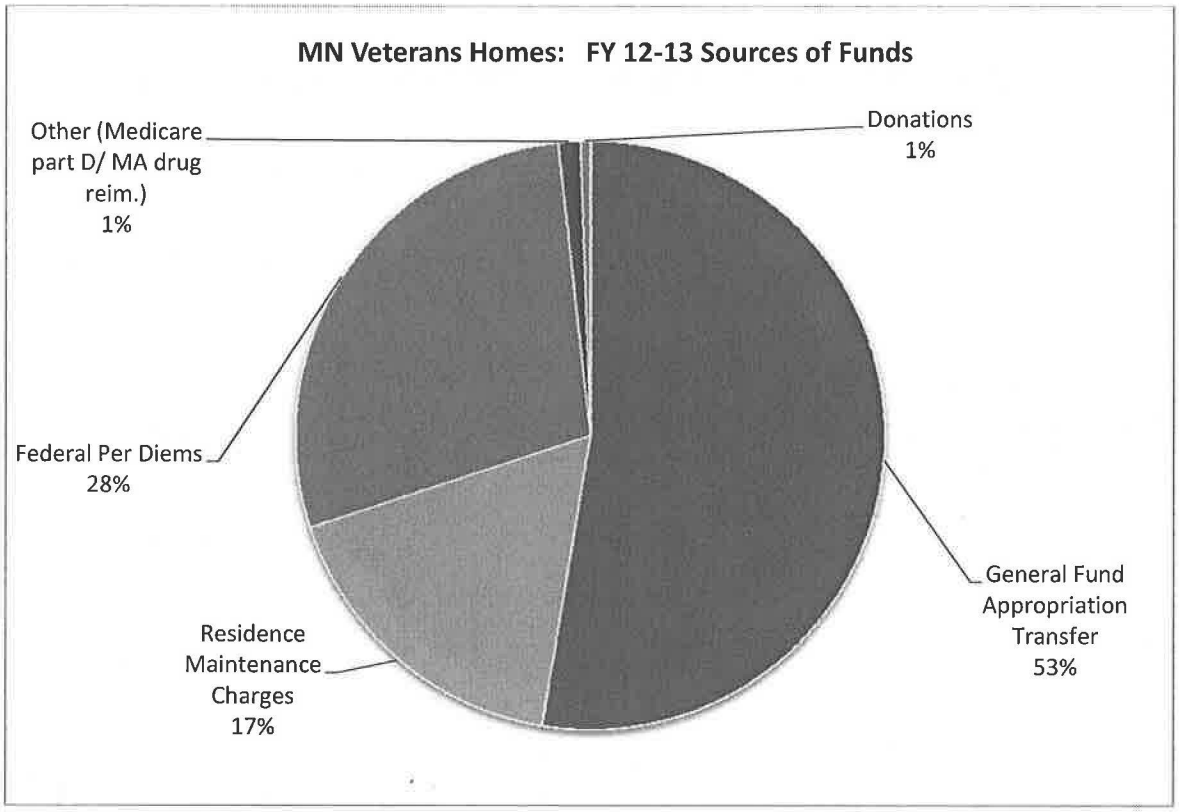
Fund	Use / Purpose	FY 12-13 Total Expenditures	
Special Revenue	Veterans Health Care	161,482	77%
General Fund	Veterans Services	25,501	12%
Federal Matching funds	Construction	21,007	10%
Misc Special Revenue	Cemetery / Leases / S.O.T.	1,451	1%
Gift Fund / Donations	Gifts / Various	928	0%
			100
(dollars in thousands)		210,369	%

[1] Excluding resident's trust funds

Information on revenues and expenditures compiled from SWIFT (state accounting system

Expenditures for the Veterans Health Care program for fiscal years 2012-13 were $161.5 million, or 77 percent, of the Department's budget. This program provides skilled nursing care, special care units for treatment of dementia, and domiciliary care.

The Veterans Health Care activities are funded through a state general fund appropriation, resident maintenance charges, U.S. Department of Veterans Affairs per diems, and donations. The General Fund appropriation is transferred to an account in the Special Revenue fund, where it is combined with the revenues from the resident payments and federal per diems. Expenditures for the five state Veterans Homes are made from this Special Revenue account.

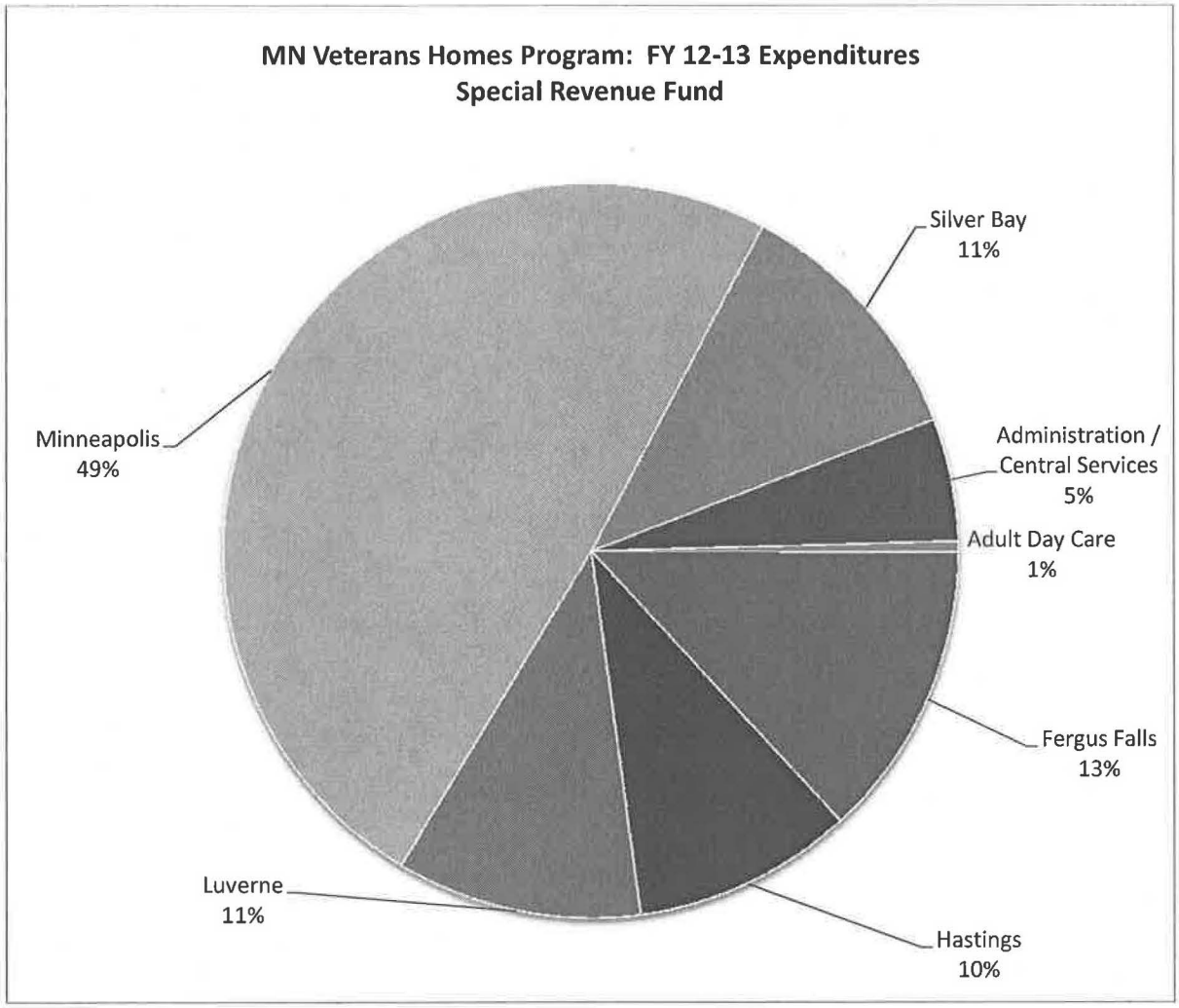


MDVA: Veterans Homes Sources of Funds, FY 2012-13

(dollars in thousands)

Veterans Homes: FY 12-13 Sources		
General Fund Appropriation Transfer	88,732	52.6%
Residence Maintenance Charges	29,216	17.3%
Federal Per Diems	47,710	28.3%
Other (Medicare part D/ MA drug reimbursement)	2,050	1.2%
Donations	947	0.6%
	168,655	100.0%

Information on revenues and expenditures compiled from SWIFT (state accounting system



MN Department of Veterans Affairs: Expenditures by Home
(dollars in thousands)

Home / Location	Total FY 2012-13 Expenditures	
Administration / Central Services	8,717	5%
Adult Day Care	798	0.5%
Fergus Falls	21,117	13.1%
Hastings	15,737	9.7%
Luverne	17,392	10.8%
Minneapolis	79,318	49.1%
Silver Bay	18,403	11.4%
	161,482	**100%**

Information on revenues and expenditures compiled from SWIFT (state accounting system

APPENDIX N

TERMS AND ABBREVIATIONS

TERM/ABBREVIATIONS	DEFINITION
Adult Day Health Care	Adult Day Health Care is a program veterans can go to during the day for social activities, peer support, companionship, and recreation. It is for veterans who need skilled services, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines), are isolated, or their caregiver is experiencing burden. Adult Day Health Care can be used in combination with other home- and community-based services. Health services such as care from nurses, therapists, social workers, and others may also be available. Adult Day Health Care can provide respite care for a family caregiver and can also help veterans and their caregiver gain skills to manage the veteran's care at home. Adult Day Health Care may be provided at VA medical centers, state veterans homes, or community organizations.
CMS	The Centers for Medicare and Medicaid Services provides Medicare and Medicaid compliance with federal law and certification for skilled nursing homes and nursing facilities to accept Medicare and Medicaid.
Domiciliary	Established through legislation passed in the late 1860's, the domiciliary's purpose was to provide a home for disabled volunteer soldiers of the Civil War. Domiciliary care was initially established to provide services to economically-disadvantaged veterans, and it remains committed to serving that group. The domiciliary has evolved from a "soldiers' home" to become an active clinical rehabilitation and treatment program for male and female veterans. Domiciliary programs are now integrated with the **Mental Health Residential Rehabilitation and Treatment Programs (MH RRTPs),** MH RRTPs are designed to provide state-of-the-art, high-quality residential rehabilitation and treatment services for veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness.
Full Cost of Care	The cost must be determined yearly based upon the average cost per resident taking into account, but not limited to, administrative cost of the homes, the cost of service available to the resident, and food and lodging costs. These average costs must be calculated separately for domiciliary and nursing care residents. The amount charged to each resident for maintenance, if anything, must be based on the appropriate average cost of care calculation and the assets and income of the resident but must not exceed the appropriate average cost of care. Minn. Stat. § 198.03, subd. 2. The calculation of the cost of care includes both the direct and indirect costs of providing resident care. These costs must be compiled separately for each facility operated by the Commissioner of Veterans Affairs on the basis of whether nursing home or boarding care services are provided.

TERM/ABBREVIATIONS	DEFINITION
Per Diem	A daily payment to reimburse for care and housing; the VA has different per diem payment rates for different levels of care/housing provided by VA programs, state programs, and non-profits.
Skilled Nursing Care (SNF)	Skilled nursing care is the level of care provided in nusring homes that requires nurses on staff 24 hours per day. The care is usually the highest level of medical need before a hospital and can include medical care, feeding, dressing, bathing, and occupational and physical therapy, as well as care for patients with dementia. The facilities are inspected by the Minnesota Department of Human Services and licensed in Minnesota by the Department of Health.
SVH	State Veterans Home
RFP	Request for proposals for funding
VA	U.S. Department of Veterans Affairs