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Medical

Book I

Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Supplement No. 100

Covering period of *Federal Register* issues
through May 1, 2016

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GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Supplement No. 100

5 May 2016

Covering the period of Federal Register issues
through May 1, 2016

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

**To ensure accuracy and timeliness of your materials,
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1. Always file your supplemental materials immediately upon receipt.
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4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.
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FILING INSTRUCTIONS

**Book I, Supplement No. 100
May 5, 2016**

<i>Remove these old pages</i>	<i>Add these new pages</i>	<i>Section(s) Affected</i>
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**Do not file this supplement until you confirm that
all prior supplements have been filed**

17.805-1 to 17.905-1	17.805-1 to 17.905-1	§§17.900, 17.902, 17.903 & 17.904
61.64-1 to 61.64-2	61.64-1 to 61.64-2	§61.64
62.62-1 to 62.62-2	62.62-1 to 62.62-2	§62.62

**Be sure to complete the
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HIGHLIGHTS

Book I, Supplement No. 100 May 5, 2016

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 4 April 2016, the VA published a final rule effective that same day, to amend or establish their regulations regarding the participation of faith-based and other community organizations in programs that the Federal agencies administer. These regulations clarify those principles and add certain protections for beneficiaries of Federal social service programs. Changes:

- In §61.64, revised paragraphs (a), (b)(1)(i), (b)(2), (c), (d) and (g); and
- In §62.62, revised paragraphs (a), (b)(1)(i), (b)(2), (c), (d) and (g).

2. On 6 April 2016, the VA published a final rule effective that same day, to amend its regulations concerning the provision of health care to birth children of Vietnam veterans and veterans of covered service in Korea diagnosed with spina bifida, except for spina bifida occulta, and certain other birth defects. Changes:

- In §17.900, revised definition of *Approved health care provider*; *Health care*, *Outpatient care*, and *Respite care*;
- In §17.900, added definitions for *Day health care*, *Health-related services*, *Home health aide services*, *Homemaker services*, *Long-term care*, and *Other place of residence*;
- In §17.902, revised paragraph (a), introductory text; and
- In §17.903, revised paragraph (a)(1).



§17.805 Additional terms of loans.

In the operation of each residence established with the assistance of the loan, the recipient must agree to the following:

- (a) The use of alcohol or any illegal drugs in the residence will be prohibited;
- (b) Any resident who violates the prohibition of alcohol or any illegal drugs will be expelled from the residence;
- (c) The cost of maintaining the residence, including fees for rent and utilities, will be paid by residents;
- (d) The residents will, through a majority vote of the residents, otherwise establish policies governing the conditions of the residence, including the manner in which applications for residence are approved;
- (e) The residence will be operated solely as a residence for not less than six veterans.
(Authority: Sec. 8 of Pub. L. 102-54, 105 Stat. 271, 38 U.S.C. 501)

Next Section is §17.900

Health Care Benefits for Certain Children of Vietnam Veterans and Veterans with Covered Service in Korea—Spina Bifida and Covered Birth Defects

*Source for §§17.900–17.905 — 62 FR 51284, Sept. 30, 1997,
unless otherwise indicated.*

§17.900 Definitions.

For purposes of §§17.900 through 17.905:

Approved health care provider means a health care provider currently approved by the Center for Medicare and Medicaid Services (CMS), Department of Defense TRICARE Program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), The Joint Commission, or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction. An entity or individual will be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate.

Child for purposes of spina bifida means the same as *individual* as defined at §3.814(c)(3) or §3.815(c)(2) of this title and for purposes of covered birth defects means the same as *individual* as defined at §3.815(c)(2) of this title.

Covered birth defect means the same as defined at §3.815(c)(3) of this title and also includes complications or medical conditions that are associated with the covered birth defect(s) according to the scientific literature.

Day health care means a therapeutic program prescribed by an approved health care provider that provides necessary medical services, rehabilitation, therapeutic activities, socialization, nutrition, and transportation services in a congregate setting. Day health care may be provided as a component of outpatient care or respite care.

Habilitative and rehabilitative care means such professional, counseling, and guidance services and such treatment programs (other than vocational training under 38 U.S.C. 1804 or 1814) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

Health care means home care, hospital care, long-term care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care; and includes the training of appropriate members of a child's family or household in the care of the child; and the provision of such pharmaceuticals, supplies (including continence-related supplies such as catheters, pads, and diapers), equipment (including durable medical equipment), devices, appliances, assistive technology, direct transportation costs to and from

approved health care providers (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants), and other materials as the Secretary determines necessary.

Health care provider means any entity or individual that furnishes health care, including specialized clinics, health care plans, insurers, organizations, and institutions.

Health-related services means homemaker or home health aide services furnished in the individual's home or other place of residence to the extent that those services provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living that have therapeutic value.

Home care means medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to a child in the child's home or other place of residence.

Home health aide services is a component of health-related services providing personal care and related support services to an individual in the home or other place of residence. Home health aide services may include assistance with Activities of Daily Living such as: Bathing; toileting; eating; dressing; aid in ambulating or transfers; active and passive exercises; assistance with medical equipment; and routine health monitoring. Home health aide services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Homemaker services is a component of health-related services encompassing certain activities that help to maintain a safe, healthy environment for an individual in the home or other place of residence. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care. Homemaker services include assistance with personal care; home management; completion of simple household tasks; nutrition, including menu planning and meal preparation; consumer education; and hygiene education. Homemaker services may include assistance with Instrumental Activities of Daily Living, such as: Light housekeeping; laundering; meal preparation; necessary services to maintain a safe and sanitary environment in the areas of the home used by the individual; and services essential to the comfort and cleanliness of the individual and ensuring individual safety. Homemaker services must be provided according to the individual's written plan of care and must be prescribed by an approved health care provider.

Hospital care means care and treatment furnished to a child who has been admitted to a hospital as a patient.

Long-term care means home care, nursing home care, and respite care.

Nursing home care means care and treatment furnished to a child who has been admitted to a nursing home as a resident.

Other place of residence includes an assisted living facility or residential group home

Outpatient care means care and treatment, including day health care and preventive health services, furnished to a child other than hospital care or nursing home care.

Preventive care means care, including day health care, furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Respite care means care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Spina bifida means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or medical conditions that are associated with spina bifida according to the scientific literature).

Veteran with covered service in Korea for purposes of spina bifida means the same as defined at §3.814(c)(2) of this title.

Vietnam veteran for purposes of spina bifida means the same as defined at §3.814(c)(1) or §3.815(c)(1) of this title and for purposes of covered birth defects means the same as defined at §3.815(c)(1) of this title. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1821, 1831)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011; 79 FR 54616, Sep. 12, 2014; 81 FR 19890, Apr. 6, 2016]

Supplement *Highlights* reference: 13(1), 60(2), 86(1), 100(2).

[Reserved]

§17.901 Provision of health care.

(a) *Spina bifida.* VA will provide a Vietnam veteran or veteran with covered service in Korea's child who has been determined under §3.814 or §3.815 of this title to suffer from spina bifida with health care as the Secretary determines is needed. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(b) *Covered birth defects.* VA will provide a woman Vietnam veteran's child who has been determined under §3.815 of this title to suffer from covered birth defects (other than spina bifida) with such health care as the Secretary determines is needed by the child for the covered birth defects. However, if VA has determined for a particular covered birth defect that §3.815(a)(2) of this title applies (concerning affirmative evidence of cause other than the mother's service during the Vietnam era), no benefits or assistance will be provided under this section with respect to that particular birth defect.

(c) *Providers of care.* Health care provided under this section will be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider.

(d) *Submission of information.* For purposes of §§17.900 through 17.905:

- (1) The telephone number of the Health Administration Center is 888/820-1756;
- (2) The facsimile number of the Health Administration Center is 303/331-7807;
- (3) The hand-delivery address of the Health Administration Center is 3773 Cherry Creek Drive North, Denver, CO 80246; and
- (4) The mailing address of the Health Administration Center for claims submitted pursuant to either paragraph (a) or (b) of this section is P.O. Box 469065, Denver, CO 80246-9065. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

Note to §17.901: Under this program, beneficiaries with spina bifida will receive comprehensive care through the Department of Veterans Affairs. However, the health care benefits available under this section to children with other covered birth defects are not comprehensive, and VA will furnish them only health care services that are related to their covered birth defects. With respect to covered children suffering from spina bifida, VA is the exclusive payer for services paid under 17.900 through 17.905, regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. As to children with other covered birth defects, any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to the covered birth defects.

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011]

Supplement *Highlights* reference: 13(1), 60(2).

§17.902 Preauthorization.

(a) Preauthorization from VA is required for the following services or benefits under §§17.900 through 17.905: Rental or purchase of durable medical equipment with a total rental or purchase price in excess of \$300, respectively; day health care provided as outpatient care; dental services; homemaker services; outpatient mental health services in excess of 23 visits in a calendar year; substance abuse treatment; training; transplantation services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in spina bifida cases where it is demonstrated that the care is medically necessary. In cases of other covered birth defects, authorization will only be given where it is demonstrated that the care is medically necessary and related to the covered birth defects. Requests for provision of health care requiring preauthorization shall be made to the Health Administration Center and may be made by telephone, facsimile, mail, or hand delivery. The application must contain the following:

- (1) Name of child,
- (2) Child's Social Security number,
- (3) Name of veteran,
- (4) Veteran's Social Security number,
- (5) Type of service requested,
- (6) Medical justification,
- (7) Estimated cost, and
- (8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization is not required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone to the Health Administration Center within 72 hours of the emergency. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0219.)

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011; 81 FR 19890, Apr. 6, 2016]

Supplement *Highlights* reference: 13(1), 60(2), 100(2).

§17.903 Payment.

(a) (1) Payment for services or benefits under §§17.900 through 17.905 will be determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see §17.270). For those services or benefits covered by §§17.900 through 17.905 but not covered by CHAMPVA we will use payment methodologies the same or similar to those used for equivalent services or benefits provided to veterans.

(2) As a condition of payment, the services must have occurred:

(i) For spina bifida, on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under §3.814 of this title.

(ii) For covered birth defects, on or after December 1, 2001, and must have occurred on or after the date the child was determined eligible for benefits under §3.815 of this title.

(3) Claims from approved health care providers must be filed with the Health Administration Center in writing (facsimile, mail, hand delivery, or electronically) no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility.

(4) Claims for health care provided under the provisions of §§17.900 through 17.905 must contain, as appropriate, the information set forth in paragraphs (a)(4)(i) through (a)(4)(v) of this section.

(i) Patient identification information:

- (A) Full name,
- (B) Address,
- (C) Date of birth, and
- (D) Social Security number.

(ii) Provider identification information (inpatient and outpatient services):

- (A) Full name and address (such as hospital or physician),
- (B) Remittance address,
- (C) Address where services were rendered,
- (D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and
- (E) Provider tax identification number (TIN) or Social Security number.

(iii) Patient treatment information (long-term care or institutional services):

- (A) Dates of service (specific and inclusive),
- (B) Summary level itemization (by revenue code),
- (C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,
- (D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,
- (E) All secondary diagnoses,
- (F) All procedures performed,
- (G) Discharge status of the patient, and
- (H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites, and independent laboratories:

- (A) Diagnosis,
- (B) Procedure code for each procedure, service, or supply for each date of service, and
- (C) Individual billed charge for each procedure, service, or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

- (A) Name and address of pharmacy where drug was dispensed,
- (B) Name of drug,
- (C) National Drug Code (NDC) for drug provided,
- (D) Strength,
- (E) Quantity,
- (F) Date dispensed,
- (G) Pharmacy receipt for each drug dispensed (including billed charge), and
- (H) Diagnosis for which each drug is prescribed.

(b) Health care payment will be provided in accordance with the provisions of §§17.900 through 17.905. However, the following are specifically excluded from payment:

- (1) Care as part of a grant study or research program,
- (2) Care considered experimental or investigational,
- (3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,

(4) Services, procedures, or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,

(5) Services provided outside the scope of the provider's license or certification,
and

(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) *Explanation of benefits (EOB).*

(1) When a claim under the provisions of §§17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

- (i) Name and address of recipient,
- (ii) Description of services and/or supplies provided,
- (iii) Dates of services or supplies provided,
- (iv) Amount billed,
- (v) Determined allowable amount,
- (vi) To whom payment, if any, was made, and
- (vii) Reasons for denial (if applicable).

(2) [Reserved] (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0219.)

[62 FR 51284, Sept. 30, 1997, as amended at 65 FR 35283, June 2, 2000; 68 FR 1010, Jan. 8, 2003; 76 FR 4249, Jan. 25, 2011; 81 FR 19890, Apr. 6, 2016]

Supplement *Highlights* references: 13(1), 100(2).

§17.904 Review and appeal process.

For purposes of §§17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by facsimile, mail, or hand delivery) to the Health Administration Center (Attention: Director) a request for review by the Director, Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

Note to §17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0219.)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4250, Jan. 25, 2011; 81 FR 19891, Apr. 6, 2016]

Supplement *Highlights* references: 13(1), 100(2).

§17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under §§17.900 through 17.905 must be provided to VA at no cost. (Authority: 38 U.S.C. 101(2), 1802-1803, 1811-1813, 1831)

[62 FR 51284, Sept. 30, 1997, as amended at 68 FR 1010, Jan. 8, 2003; 76 FR 4250, Jan. 25 2011]

Supplement *Highlights* reference: 13(1).

Next Section is §17.1000

§61.64 Religious organizations.

(a) Organizations that are religious or faith-based are eligible, on the same basis as any other organization, to participate in VA programs under this part. Decisions about awards of Federal financial assistance must be free from political interference or even the appearance of such interference and must be made on the basis of merit, not on the basis of religion or religious belief or lack thereof.

(b) (1) No organization may use direct financial assistance from VA under this part to pay for any of the following:

(i) Explicitly religious activities such as, religious worship, instruction, or proselytization; or

(ii) Equipment or supplies to be used for any of those activities.

(2) For purposes of this section, “indirect financial assistance” means Federal assistance in which a service provider receives program funds through a voucher, certificate, agreement or other form of disbursement, as a result of the independent and private choices of individual beneficiaries. “Direct financial assistance” means that VA or an intermediary as defined in 38 CFR 50.1(d) selects the provider and either purchases services from that provider (e.g., via a contract) or awards funds to that provider to carry out a service (e.g., via grant or cooperative agreement). Financial assistance shall be treated as direct, unless it meets the definition of indirect financial assistance in this paragraph.

(c) Organizations that engage in explicitly religious activities, such as worship, religious instruction, or proselytization, must offer those services separately in time or location from any programs or services funded with direct financial assistance from VA, and participation in any of the organization's explicitly religious activities must be voluntary for the beneficiaries of a program or service funded by direct financial assistance from VA.

(d) A religious organization that participates in VA programs under this part will retain its independence from Federal, state, or local governments and may continue to carry out its mission, including the definition, practice and expression of its religious beliefs, provided that it does not use direct financial assistance from VA under this part to support any explicitly religious activities, such as worship, religious instruction, or proselytization. Among other things, faith-based organizations may use space in their facilities to provide VA-funded services under this part, without removing religious art, icons, scripture, or other religious symbols. In addition, a VA-funded religious organization retains its authority over its internal governance, and it may retain religious terms in its organization's name, select its board members and otherwise govern itself on a religious basis, and include religious reference in its organization's mission statements and other governing documents.

(e) An organization that participates in a VA program under this part shall not, in providing direct program assistance, discriminate against a program beneficiary or prospective program

beneficiary regarding housing, supportive services, or technical assistance, on the basis of religion or religious belief.

(f) If a state or local government voluntarily contributes its own funds to supplement Federally funded activities, the state or local government has the option to segregate the Federal funds or commingle them. However, if the funds are commingled, this provision applies to all of the commingled funds.

(g) To the extent otherwise permitted by Federal law, the restrictions on explicitly religious activities set forth in this section do not apply where VA funds are provided to religious organizations through indirect assistance as a result of a genuine and independent private choice of a beneficiary, provided the religious organizations otherwise satisfy the requirements of this part. A religious organization may receive such funds as the result of a beneficiary's genuine and independent choice if, for example, a beneficiary redeems a voucher, coupon, or certificate, allowing the beneficiary to direct where funds are to be paid, or a similar funding mechanism provided to that beneficiary and designed to give that beneficiary a choice among providers.

(Authority: 38 U.S.C. 501)

[78 FR 12613, Feb. 25, 2013; as amended at 81 FR 19425, Apr. 4, 2016]

Supplement *Highlights* references: 75(1), 100(1)

§62.62 Religious organizations.

(a) Organizations that are religious or faith-based are eligible, on the same basis as any other organization, to participate in the Supportive Services for Veteran Families Program under this part. Decisions about awards of Federal financial assistance must be free from political interference or even the appearance of such interference and must be made on the basis of merit, not on the basis of religion or religious belief or lack thereof.

(b) (1) No organization may use direct financial assistance from VA under this part to pay for any of the following:

(i) Explicitly religious activities, such as religious worship, instruction, or proselytization; or

(ii) Equipment or supplies to be used for any of those activities.

(2) For purposes of this section, “indirect financial assistance” means Federal assistance in which a service provider receives program funds through a voucher, certificate, agreement, or other form of disbursement, as a result of the independent and private choices of individual beneficiaries. “Direct financial assistance” means that VA or an intermediary as defined in 38 CFR 50.1(d) selects the provider and either purchases services from that provider (e.g., via a contract) or awards funds to that provider to carry out a service (e.g., via grant or cooperative agreement). Financial assistance shall be treated as direct, unless it meets the definition of indirect financial assistance in this paragraph.

(c) Organizations that engage in explicitly religious activities, such as worship, religious instruction, or proselytization, must offer those services separately in time or location from any programs or services funded with direct financial assistance from VA under this part, and participation in any of the organization’s explicitly religious activities must be voluntary for the beneficiaries of a program or service funded by direct financial assistance from VA under this part.

(d) A religious organization that participates in the Supportive Services for Veteran Families Program under this part will retain its independence from Federal, State, or local governments and may continue to carry out its mission, including the definition, practice, and expression of its religious beliefs, provided that it does not use direct financial assistance from VA under this part to support any explicitly religious activities, such as worship, religious instruction, or proselytization. Among other things, faith-based organizations may use space in their facilities to provide VA-funded services under this part, without removing religious art, icons, scripture, or other religious symbols. In addition, a VA-funded religious organization retains its authority over its internal government, and it may retain religious terms in its organization’s name, select its board members and otherwise govern itself on a religious basis, and include religious reference in its organization’s mission statement and other governing documents.

(e) An organization that participates in a VA program under this part must not, in providing direct program assistance, discriminate against a program beneficiary or a prospective program beneficiary regarding supportive services, financial assistance, or technical assistance, on the basis of religion or religious belief.

(f) If a State or local government voluntarily contributes its own funds to supplement federally funded activities, the State or local government has the option to segregate the Federal funds or commingle them. However, if the funds are commingled, this provision applies to all of the commingled funds.

(g) To the extent otherwise permitted by Federal law, the restrictions on explicitly religious activities set forth in this section do not apply where VA funds are provided to religious organizations through indirect assistance as a result of a genuine and independent private choice of a beneficiary, provided the religious organizations otherwise satisfy the requirements of this part. A religious organization may receive such funds as the result of a beneficiary's genuine and independent choice if, for example, a beneficiary redeems a voucher, coupon, or certificate, allowing the beneficiary to direct where funds are to be paid, or a similar funding mechanism provided to that beneficiary and designed to give that beneficiary a choice among providers. (Authority: 38 U.S.C. 501, 2044)

[75 FR 68979, Nov. 10, 2010; as amended at 81 FR 19425, Apr. 4, 2016]

Supplement *Highlights* references: 58(1), 100(1)