Care Provider Statement

Name of Claimant:	Social Security #:
Name of Veteran:	Social Security #:

Facility/ Agency Information (to be completed By a Facility/ Agency Official)

Name of Care Facility/ Agency:	Address:
Phone#:	

Type of service provided: (*please circle*)	Skilled Nursing Home	Assisted Living Facility	Rest Home (Senior Living Facility)	Home Care Agency Hourly Rate:_____ Hours/Mo:_____

Date serviced began (*Month, Day, Year*) _____/_____/_____	Does Medicaid Pay any Portion of the monthly care expense: **YES / NO** (*if yes, provide a breakdown on a separate page*)
Amount claimant is responsible for out of pocket each Month $_____	Amount claimant is expected to pay out of pocket in the next 12 months $_____

This facility/ Agency provides the following services:

Services:	**Yes**	**No**
Assistance with Activities of Daily Living (dressing, bathing, toileting, hygiene)	☐	☐
Daily monitoring of claimant to ensure health, safety, nutrition, etc.	☐	☐
24 hour on-sight staff to monitor and respond to emergency alert system	☐	☐
"Protected environment" to protect the claimant from the hazards and dangers of daily living	☐	☐
"Secure environment"- entry and exit of the facility is monitored 24 hours/day	☐	☐
Medication management	☐	☐
Meal Preparation	☐	☐
Assistance with Ambulating	☐	☐
Homemaker services	☐	☐
Transportaion to medical appointments	☐	☐

I certify that the claimant requires the services of this facility/ agency because of mental or physical disabilities and is receiving such care/ services.

Signature of Official:	Title:
Official's Printed Name:	Date Signed: