CARE EXPENSE STATEMENT

Please note that both you and the administrator of your facility/your care provider must sign and date the last section, or we will not be able to consider these expenses.

Veteran's name: _____

Patient's name: _____

Name of facility or care provider: _____

Phone number of facility or care provider: _____

Address of facility or care provider: _____

_____

_____

Date entered facility or in-home care began: _____

Date patient left facility (if applicable): _____

Will the patient need this care indefinitely? Yes____ No____

If No, when will the care end? _____

Has the patient applied for Medicaid? Yes____ No____

Is part of the patient's cost covered by
Medicaid, Medicare, or insurance? Yes____ No____

When did coverage begin? _____

What monthly amount does the veteran or patient pay from his/her own funds?

Effective date: _____ $_____ per month

(prior) Effective date: _____ $_____ per month

FOR NURSING HOME CARE, ALSO ANSWER:

Is your facility licensed by the State? Yes____ No____

Is your facility Medicaid approved? Yes____ No____

Is the patient in your nursing home because of physical or mental disability? Yes____ No____

Do you provide either skilled or intermediate level nursing care to the patient? Yes____ No____

What was the admitting diagnosis? _____

_____

FOR IN-HOME CARE, ALSO ANSWER:

Which of the following services do you provide?

___ Assistance with bathing and/or showering

___ Assistance with dressing

___ Assistance with eating and/or drinking (not including meal preparation)

___ Assistance with mobility (i.e. getting in or out of bed, a chair, etc.)

___ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

Describe additional medical or nursing services you provide:

_____

_____

Are you a licensed health professional? Yes____ No____
(registered nurse, licensed vocational nurse, or licensed practical nurse)

If yes, provide your license number: _____

If you charge by the hour, please list your hourly rate and weekly hours worked:

Weekly Hours: _____ $_____ per hour

FOR OTHER TYPES OF CARE FACILITIES, ALSO ANSWER:

Indicate type of facility in which the claimant resides:

____ Foster Home ____ Adult Day Care

____ Rest Home ____ Group Home

____ Assisted Living ____ Independent Living/Retirement Facility

Which of the following services do you provide?

___ Assistance with bathing and/or showering

___ Assistance with dressing

___ Assistance with eating and/or drinking (not including meal preparation)

___ Assistance with mobility (i.e. getting in or out of bed, a chair, etc.)

___ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

Describe additional medical or nursing services you provide:

_____

_____

If a third party provides the services listed above, please list their name, address, and phone number:

_____

_____

_____

Important: Please have the third party complete the in-home care section above and sign and date the last section.

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional? Yes____ No____
(registered nurse, licensed vocational nurse, or licensed practical nurse)

We must have the monthly charge broken down into the following two categories:

1. Base Rate: $_____ per month
   (includes room, meals, laundry, housekeeping, etc.)

2. Medical and Nursing Services: $_____ per month

SIGNATURES:

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____

Signature of Facility Administrator or Care Provider Date

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____

Signature of third party contractor (if applicable) Date

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_____ per month for my care from my own funds.

_____

Signature of Veteran or Beneficiary Date