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

Date services 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 hours 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	☐	☐
Transportation 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: