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: