Care Expense Statement

Section 1: General Information (To be completed by the facility administrator. Please Print.)

VA Claim Number or SSN:

Veterans Name:

Patient's Name:

Check the box which describes the patient's care status:

- ☐ In Home Care
- ☐ Nursing Home Care
- ☐ Other Care Facility *(Foster Home, Adult Day Care, Rest Home, Group Home, Assisted Living)*

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 _____

Will the patient need this care indefinitely ☐ Yes ☐ No

If No, when will the care end? _____

Total monthly charge for the patient $_____ per month:

Has the patient applied for Medi-Cal (Medicaid) ☐ Yes ☐ No

Is part of the patient's cost covered by Medicaid, Medicare, or insurance ☐ Yes ☐ No

If Yes, please answer the following:

What is the source of payment? _____

What is the monthly amount covered by this source? $_____ per month:

When did coverage begin? _____

What monthly amount does the veteran or patient pay from his/her own funds which is not reimbursed by one of the sources listed above? $_____ per month:

(*If the patient is receiving Medicaid, what amount does Medicaid take from the patient*)

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Be sure to sign and date

Section 2: In-Home Care Information

(To be completed by the care provider only if patient is being provided In-Home Care)

Do You provide any medical or nursing services for the patient? ☐ Yes ☐ No
(i.e. administering medication, physical or mental therapy, assisting with personal hygiene, dressing bathing; etc.)

Describe the services you provide:_____

Are you a licensed health professional? (RN, LVN or LPN) ☐ Yes ☐ No
If Yes, provide your license number: _____

Section 3: Nursing Home Information

(To be completed by the facility administrator only if the patient is in a nursing home.)

Is your facility licensed by the State? ☐ Yes ☐ No

Is your facility Medicaid (Medi-Cal) approved? ☐ Yes ☐ No

Is the patient in your nursing home because of a 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? _____

Section 4: Other Care Facility Information

(To be completed by the facility administrator only if the patient is in a foster home, adult day care, rest home, group home or assisted living)

Indicate type of facility ☐ Assisted Living ☐ Rest Home ☐ Foster Home
☐ Adult Day Care ☐ Group Home ☐ Other _____

Do you provide any medical or nursing services for the patient? ☐ Yes ☐ No
(i.e. administering medication, physical or mental therapy, assisting with personal hygiene, dressing bathing; etc.)

Describe the services you provide: _____

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional (RN, LVN, LPN) ☐ Yes ☐ No

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

1. Base Rate (includes room, meals, laundry, housekeeping): $_____ per month:
2. Medical and Nursing Services: $_____ per month:

Section 5: Signatures *(To be completed by the facility administrator/care provider and veteran/widow)*

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. I am paying $_____ per month for my care from my own funds.

_____ _____
Signature of Veteran or Beneficiary Date