ATTENDANT AFFIDAVIT

RE: _____
Veteran's Name – Last, First, Middle

_____
VA Claim or Social Security Number

_____
Claimant's Name

_____
Claimant's Address (Street)

_____
City, State and Zip Code

My Name is_____, and I provide health care for the above named claimant.

The services which I provide:

☐	Yes	☐	No	Assistance with bathing
☐	Yes	☐	No	Standing and sitting
☐	Yes	☐	No	Getting in and out of bed
☐	Yes	☐	No	Spoon Feeding
☐	Yes	☐	No	Walking
☐	Yes	☐	No	Dressing and undressing
☐	Yes	☐	No	Taking medication
☐	Other (Please describe)_____			

For these services, I am paid by the claimant _____per day / week / month / year (please circle only one)

I began my employment on_____

_____
Signature of provider

_____
Street address

_____
City, State, and Zip Code

_____
Phone Number (including area code)

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount I listed for the services listed . (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature:_____ Date_____

Witness: _____ Date _____

Witness: _____ Date _____