Care Expense Statement

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

A. Social Security Number of the Veteran: _____

B. Veterans Name: _____

C. Patient's Name: _____

D: 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)*

E. Name of facility or care provider: _____

F. Phone number of facility or care provider: _____

G. Address of facility or care provider: _____

_____

H. Date entered facility or in home care began _____

I. Will the patient need this care indefinitely ☐ Yes ☐ No

If No, when will the care end? _____

J. Total monthly charge for the patient $_____ per month:

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

L. Is part of the patient's cost covered by Medicaid, Medicare, Insurance or other source? ☐ 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? _____

M. What amount does the veteran or patient pay from their own funds which is not reimbursed by one of the sources above? $_____ per month:

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Be sure to sign and date

Section 2: In-Home Care *(To be completed by the care provider)*

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

B. Describe the services you provide:_____

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

Section 3: Skilled Nursing Facility *(To be completed by the facility administrator)*

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

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

C. Is the patient in your facility because of a physical or mental disability? ☐ Yes ☐ No

D. Do you provide skilled or intermediate level nursing care to the patient? ☐ Yes ☐ No

E. What was the admitting diagnosis? _____

Section 4: Other Care Facility *(To be completed by the facility administrator)*

A. Type of facility ☐ Assisted Living ☐ Rest Home ☐ Foster Home
☐ Adult Day Care ☐ Group Home ☐ Other _____

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

C. Describe the services you provide:_____

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

E. 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