

Care Expense Statement

Section 1: General Information *(To be completed by the facility administrator or care provider. Please print.)*

VA claim number: _____

Veteran's 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, or 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

***Total Paid to provider by claimant in year** _____.

\$ _____

***Has the patient applied for Medicaid?** Yes No

***When did patient apply for Medicaid?** _____.

***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 the 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?** *(If the patient is receiving Medicaid, what amount does Medicaid take from the patient?)* \$ _____ per month

If the patient is receiving Medicaid, attach a copy of the SDS-512 Medicaid Form.

Continue on page 2.
Be sure to sign and date in Section 6. → → → →

Section 2: In-Home Care Information (To be completed by the care provider only if the patient is being provided in-home care.)

*** Do you provide any medical or nursing services for the patient?**

(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing; etc.)

Yes No

***Describe the services you provide:** _____

***Are you a licensed health professional?** (registered nurse, licensed vocational nurse, or licensed practical nurse) Yes No

If Yes, provide your license number: _____

Which of the following services do you provide?

_____ Assistance with bathing and /or showering

_____ Assistance with dressing

_____ Assistance with eating and/or drinking (not including meal preparations)

_____ Assistance with mobility (i.e. getting in or out of bed, a chair, etc)

_____ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

If you charge by the hour, please list your hourly rate and weekly hours worked:

Weekly Hours: _____ \$ _____ per hour

****See Section 5 for documentation requirements for in-home care**

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 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: Foster Home Rest Home Assisted Living
 Adult Day Care Group Home Other: _____

Which of the following services do you provide?

_____ Assistance with bathing and /or showering

_____ Assistance with dressing

_____ Assistance with eating and/or drinking (not including meal preparations)

_____ Assistance with mobility (i.e. getting in or out of bed, a chair, etc)

_____ Assistance with personal hygiene needs (i.e. using the toilet, brushing teeth, etc.)

Do you provide any additional medical or nursing services for the patient? Yes No

Describe the services you provide: _____

If a 3rd party provides the services listed above, please list their name, address, and phone number: _____

Important: Please have the 3rd party complete the in-home care section above and sign and date the last section.

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional? *(registered nurse, licensed vocational nurse, or licensed practical nurse)* Yes No

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

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

Section 5: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

To allow medical expenses for in-home caregivers, VA regulations require you to submit specific documentation of expenses from all of your caregivers.

What We Need:

In order to allow fees for the in-home attendants, receipts or other documentation is required.

Documentation includes:

- A receipt bill
- Statement on the provider's letterhead
- Computer summary
- Ledger, or
- Bank statement

The Evidence Submitted Must Include

- The amount paid
- The date payment was made
- The purpose of the payment (the nature of the product or service provided)
- The name of the person to or for whom the product of service was provided
- Identification of the provider to whom payment was made

Note: A family member may be considered an in-home attendant only if he/she is actually **being paid**. Documentation must be submitted.

Section 6: Signatures *(To be completed by the facility administrator/care provider and the veteran/beneficiary.)*

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 above statements are true and correct to the best of my knowledge and belief.

Signature of 3rd party contractor (if applicable)

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