

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)

Continue on page 2
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 Yes No
provided or supervised by a licensed health professional (RN, LVN, LPN)

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