Care Expense Statement

Section 1: General Information (To be completed by the facilit	y administ	rator. 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, G	troup 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:

Section 2: In-Home Care (To be completed by the care provider)		
A. Do You provide any medical or nursing services for the patient? 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) If Yes, provide your license number:		
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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?		
C. Is the patient in your facility because of a physical or mental disability?		
D. Do you provide skilled or intermediate level nursing care to the patient?		
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? 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)		
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:		
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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		