

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: _____

****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: _____

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: _____

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 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