Reset Form

Care Expense Statement

Section 1: General Information

(To be completed by the Facility Administrator. Please Print.)

A. Social Security Number of the Veteran: _____

B. Veteran's 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 fund which is not reimbursed by one of the sources above?

$_____ per month

Continue on Page 2

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 ☐ Adult Day Care ☐ Foster Home
☐ Group Home ☐ Rest 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