

**STATEMENT BY ASSISTED LIVING OR NURSING HOME ADMINISTRATOR**

**Name of Patient:** SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Veteran:** SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern:

The above referenced patient was admitted as a resident of this Assisted Living Home on for his/her intermediate nursing care and ADL assistance.

Medicaid does not pay any amount of the monthly charges for care.

The total monthly charge of $ is paid by the Patient for his/her personal care which includes all or some of the following care services: 24-hour monitoring by licensed nurses and/or state tested Nursing Aids to ensure proper hygiene, health and ambulation assistance, bathing, grooming, dressing, incontinence care, medication management, dietitian & special diet supervision, meal preparation, cooking, eating assistance, and transportation services.

If you have any questions, please call me at .

**Assisted Living/Nursing Home Administrator**

“I certify that the claimant is a patient in this facility because of a mental or physical disability requiring the above listed aid and assistance of another individual on a regular basis.”

Name: (PRINT) Date:

Signature:

Title: