

**STATEMENT BY HOME CARE AGENCY DIRECTOR / ADMINISTRATOR**

**Name of Claimant:** SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

To Whom It May Concern:

The above referenced claimant has entered into an agreement on \_\_\_\_/\_\_\_/\_\_\_\_ with this Home Care Agency for his/her personal care and home health assistance at

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ (CITY), .

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

The total monthly charge is $ \_\_ paid by the Claimant for personal care and assistance services which include the following ADL’s: assistance and monitoring by home care Aides to ensure proper hygiene, bathing, grooming, dressing, toileting, incontinence care, medication management, meal preparation, cooking, laundry, housekeeping, ambulation assistance, and transportation services.

If you have any questions, please call me at .

 Name: (PRINT) Date:

Signature:

Title: