

Nursing Home Status Statement Aid & Attendance

This is to certify that patient, _____, has been receiving

CLAIMANT NAME

_____ level of care at _____ since

LEVEL OF CARE

FACILITY NAME

_____ and need for such care is permanent because of the following

DATE

diagnosis:

Is the claimant considered mentally capable of handling their own affairs? Yes No

SIGNATURE OF FACILITY PHYSICIAN OR PRIVATE PRACTITIONER

If State Assisted, please provide the effective date of eligibility: _____

Please provide the claimant's nursing home expenses according to the following. Please enter zero where applicable.

Out-of-pocket expenses: \$ _____

Medicaid: \$ _____

Insurance: \$ _____

Other: \$ _____

SIGNATURE OF ADMINISTRATOR

NAME OF FACILITY

DATE

ADDRESS OF FACILITY

CTY / STATE / ZIP

I hereby certify that the above is true to the best of my knowledge.

SIGNATURE OF CLAIMANT

DATE