NURSING HOME FACILITY STATUS STATEMENT
(To support application for Veterans Administration Pension for Aid & Attendance or Homebound Status)

This is to certify the following:

Facility Name: ________________________ Phone: _______________ FAX: ___________________

Address: ____

Name Facility Employee: ____ Title: _______________

Patient Name: ____________________________ Date of admission: ___________________

Level of care: _____________________

Diagnosis/Conditions: ____

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Please check all that apply:

□ Patient’s condition is considered permanent. □ Needs assistance eating

□ Needs assistance dressing or bathing □ Needs assistance toileting

□ Fall risk □ Unable to leave facility without assistance □ Requires Supervision

□ Needs assistance or reminders with medication □ Requires assistance transferring

□ Is the claimant considered mentally incapable of handling own affairs

Receiving Medicaid or State Assistance? □ Yes □ No If yes date assistance began: ______________________

Please show the claimant’s nursing home expenses with a breakdown of how these expenses will be paid. If the answer is “None”, enter zero.

Expenses paid by claimant: $___________________ Claimant’s Family:___________________

Medicaid: $_____________________ Insurance: $___________ Other: $________________

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Signature of Facility Administrator

Form provided by www.WinbladLaw.Com