

SURVIVORS PENSION BENEFITS 2024

Our staff of VA trained and accredited County Veteran Service Officers can answer your questions, assist in completing the necessary VA forms, and act as the claimant’s advocate through the claim process.

**ALL SERVICES ARE PROVIDED
FREE OF CHARGE.**

LAKE COUNTY VETERANS SERVICE OFFICE

An Office of Lake County Government
Located in Building C of the Lake County
Administration Center

105 Main St.,
Painesville, OH 44077
(440) 350-2904/2567
Fax (440) 350-5980



If you are the surviving spouse of a deceased veteran with low income or overwhelmed with the high cost of medical care, such as paying for assisted living facilities, home care aids, adult daycare, or skilled nursing, the VA Survivors benefit could be the solution to help pay for this care or other needs.

There are three levels of VA Survivors Pensions:

Basic Pension—for surviving spouses with low income

Aid & Attendance (A&A) – for surviving spouses that require assistance with their activities of daily living

Housebound – for surviving spouses with a permanent disability that prevents them from leaving their home

You may be eligible if:

- the deceased veteran was discharged from military service under other than dishonorable conditions; **AND**
- the veteran served 90 days of active duty or more with at least 1 day during a war time period*; **AND**
- your annual household income and net worth** meet certain limits set by law.

While an un-remarried spouse is eligible at any age, a child of a deceased wartime Veteran must be: under 18, **OR** under age 23 if attending a VA-approved school, **OR** permanently incapable of self-support due to a disability before age 18.

*To find the dates of service considered as war time periods, visit: www.va.gov/pension/war-time-period. Veterans who enlisted after September 7, 1980 generally must have served at least 24 months of active duty **OR** the full period for which called or ordered to active duty.

PENSION RATES effective 12/1/2023	MAXIMUM MONTHLY BENEFIT	MAXIMUM HOUSEHOLD ANNUAL INCOME***
Basic Pension with no dependents*	\$925.00	\$11,102.00
With Housebound benefits with no dependents*	\$1,130.00	\$13,568.00
With Aid and Attendance with no dependents*	\$1,478.00	\$17,743.00
In Nursing Home receiving Medicaid benefits	\$90.00	N/A

*Additional benefits are available for dependent children. Ask for details.

***** OUT OF POCKET MEDICAL EXPENSES PAID BY THE HOUSEHOLD ARE USED TO REDUCE THE HOUSEHOLD INCOME.**

Please see the examples on page 2.

**HOUSEHOLD NET WORTH LIMIT MUST BE UNDER \$155,356.00

(as of 12/01/2023—changes annually) Net worth is the sum of household assets and annual income. It does NOT include a primary residence and lot under 2 acres, automobile, or personal effects. As of 10/18/2018 the VA instituted a “look back” period of 3 years. Any assets transferred to reduce net worth after this date must be reported and may prohibit qualifying for the pension benefit for up to 5 years.

DETERMINING THE MONTHLY BENEFIT AMOUNT:

The amount of the possible benefit can be determined by totaling the amount of monthly GROSS household income and then subtracting the monthly total of continuing out of pocket medical expenses which equals the countable income. The countable income is then subtracted from the maximum monthly income limit for the veteran's situation. (See the chart on page 1.) The examples below can help you to understand how the VA calculates the amount. All amounts are monthly figures.

The Pension Worksheet on page 3 can be used to determine the possible benefit.

1. PENSION EXAMPLE:

The surviving spouse is 81 years old. Her monthly income is \$800 (GROSS) in Social Security (SS) benefits. She is still able to live alone in her home which is paid off. She has no savings or any other assets. \$174.70 is withheld from her SS benefits for Medicare and she pays \$75.00 per month for a supplemental health insurance.

Medical Expenses:		Income:		Possible Benefit:	
Medicare Part B	\$ 174.70	Social Security	\$800.00	VA Income Limit	\$925.00
Health insurance	<u>75.00</u>	Less med expenses	<u>249.70</u>	Less countable income	<u>550.30</u>
Total med exps	\$249.70	Countable income	\$550.30	VA benefit	\$374.70

2. PENSION WITH AID AND ATTENDANCE EXAMPLE:

Surviving spouse is 70 years old. His monthly income consists of \$825.00 (GROSS) in Railroad Retirement (RR) and \$1,370.00 in State Teachers Retirement. His doctor stated that he could no longer live alone, and it was a medical necessity to move into an assisted living facility but did not need full nursing home care. The monthly cost of the assisted living facility is \$3,500 per month, \$174.70 is withheld from his RR for Medicare, and he pays \$100 for supplemental health insurance.

Medical Expenses:		Income:		Possible Benefit:	
Assisted Living	\$3,500.00	RR	\$ 825.00	VA Income Limit	\$1,478.00
Medicare Part B	174.70	State Teachers	<u>1,370.00</u>	Because the claimant's income is	
Health insurance	<u>100.00</u>	Total income	\$2,195.00	less than his medical expense, his	
Total med exps	\$3,774.70	Less med exps	<u>3,774.70</u>	countable income is zero. He would	
		Countable income	0.00	receive the full benefit \$1,478.00.	

3. NURSING HOME WITH MEDICAID EXAMPLE:

The widow in example #1 becomes ill and the doctors determine she must be placed into a nursing home. Medicaid begins to pay the cost of her care and she receives just a small portion of her Social Security benefit. The VA will reduce her monthly pension benefit to **\$90 per month** which can be used for her personal needs such as clothing, haircuts, etc.

CHECKLIST OF DOCUMENTATION NEEDED TO COMPLETE THE VA FORMS FOR SURVIVORS PENSION:

The average processing time for VA **Survivors** Pension is an average of 6 to 9 months. Therefore, it is best to submit all supporting documentation with the original claim forms to expedite the process as much as possible.

FAILURE TO PROVIDE ALL DOCUMENTATION WILL DELAY THE FILING OF THE CLAIM AND A DECISION FROM THE VA.

___ **DD 214/Military Separation Record.** We can assist with obtaining this document if necessary or you can request it FREE OF CHARGE on-line at: www.archives.gov/veterans/military-service-records.

___ **Social Security numbers for claimant, veteran, and dependents.** Please also provide VA Claim number if available.

___ **Marriage Licenses and Death Certificates.**

___ **Proof of all income.** Please provide statements showing the **GROSS* amounts** (before any deductions such as Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from investments, rental or business income, long term care insurance benefits received, etc. *This amount can generally be found on annual statements from Social Security and other benefits.

___ **Current statements for all assets.** All checking, savings accounts, stocks, bonds, mutual funds, trusts, annuities, long term care insurance, savings bonds, etc.

___ **Direct deposit information and/or voided check.**

___ **Documentation regarding any transfer of assets you or your dependents have made in the last 3 tax years.** Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust.

___ **Amounts of CONTINUING monthly medical expenses.** When initially filing for the VA Pension benefit, we will report household "out of pocket" medical expenses which are the same every month. These include:

- Medicare deductions withheld from Social Security or other benefits for Parts B, C, or D.
- Supplemental insurance premiums for health, dental, prescriptions, vision plans, etc. (sometimes withheld from pension/retirement benefits)
- Prescriptions/over the counter medications/medical supplies (i.e. incontinence supplies) which are the same every month
- Long term care insurance premiums
- Final funeral/burial expenses paid by the veteran for spouse in the last year
- Amounts paid for in home health care, adult day care, assisted living, and nursing home

___ **Documentation from the Ohio Department of Jobs and Family Services (ODJFS) regarding Medicaid.**

___ **Any Guardianship Appointments or Power of Attorneys.**

If the claimant is in a Nursing Home:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. **AND**

___ **VA Form 21-0779 included in this packet** (Request for Nursing Home Information)

If the claimant is in an Assisted Living, Adult Day Care, or similar facility:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician **AND**

___ **VA Form 21P-534EZ, page 19 included in this packet** (Worksheet for Residential Care, etc.)

If the claimant receives medical care from an In-Home Care Attendant:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. **AND**

___ **VA Form 21P-534EZ, page 20 included in this packet** (Worksheet for an In-Home Attendant)

VETERAN'S SOCIAL SECURITY NUMBER

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SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

- YES (If "YES," complete Items 14B, 14C & 14D)
 NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

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14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)

15B. DATE SIGNED (MM/DD/YYYY)

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**SECTION VI: EXAMINATION INFORMATION
 (IMPORTANT: Remainder of form MUST be filled out by Examiner)**

NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

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NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.	D.
B.	E.
C.	F.

19A. AGE

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19B. WEIGHT

ACTUAL LBS.

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 ESTIMATED LBS.

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19C. HEIGHT

FEET

--

 INCHES

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20. NUTRITION

21. GAIT

22. BLOOD PRESSURE

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23. PULSE RATE

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24. RESPIRATORY RATE

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25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

VETERAN'S SOCIAL SECURITY NUMBER - -

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- BATHING/SHOWERING TENDING TO HYGIENE NEEDS ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
- EATING OR SELF-FEEDING TRANSFERRING IN OR OUT OF BED/CHAIR
- DRESSING TOILETING
- AMBULATING WITHIN THE HOME OR LIVING AREA MEDICATION MANAGEMENT

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- YES
 NO

28B. CORRECTED VISION

LEFT EYE

RIGHT EYE

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

- YES
 NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- YES
 NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (NOTE: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

VETERAN'S SOCIAL SECURITY NUMBER - -

35. DESCRIBE ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

YES (If "YES," check the applicable box or specify distance) 1 BLOCK 5 OR 6 BLOCKS 1 MILE OTHER (Specify distance) _____
 NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER

39. TITLE OF EXAMINER

40. SIGNATURE OF EXAMINER (REQUIRED)

41. DATE SIGNED (MM/DD/YYYY)

- -

SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

- - Enter International Phone Number (If applicable)

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet website at <http://www.reginfo.gov/public/do/PRAMain>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

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3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

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4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

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5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

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6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

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Apt./Unit Number

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 City

--

State/Province

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 Country

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 ZIP Code

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7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> </tr> </table>		/		/				12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> </tr> </table> <input type="radio"/> INDEFINITE		/		/			
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13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

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 PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%; height: 20px;"></td> </tr> </table>		/		/			
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WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

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3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

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6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

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Apt./Unit Number

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 City

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State/Province

--

 Country

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 ZIP Code

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

- A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

- A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

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12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

	/		/		<input type="radio"/> INDEFINITE
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13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

\$

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 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

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 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

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