CARE PROVIDER CERTIFICATION OF SERVICES - Form FV13

1. Name of Person Receiving Care Services	2. Name of Veteran (For VA Purposes)		3. Veteran Social Security Number or VA Case Number	
4. Address of Person Receiving Care Services	5. City	6. State	7. Zip	8. Phone(s) and email
9. Name of Care Service Provider	10. Complete Address and Phone Number of the Care Service Provider			

Check the appropriate box below for the type of service offered by the care provider.

Residential Care Facility ☐ Assisted Living ☐ Professional Home Care Company ☐

Nursing Home ☐ Adult Day (Care) Service ☐ Private In-Home Attendant ☐

Adult Foster Care ☐ Adult Family Home ☐

If care provider provides 24-hour permanent residence for the care recipient, fill in the information below.

Date service started _____

Monthly charges including room and board, extras and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance during the day at a location other than the care recipient's home, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Monthly charges including meals, site-to-site transportation and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance in the home of the care recipient or in the home of someone else, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Please attach a copy of the care provider contract.

Monthly charges including meals, transportation, housework and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid.")

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

Form FV13 - CARE PROVIDER CERTIFICATION OF SERVICES - Page 2

COMPLETE THIS SECTION FOR ASSISTED LIVING, HOME CARE, ADULT DAY CARE, NURSING HOME, IN-HOME ATTENDANT, etc

Please describe briefly the "**protected environment**" and/or care services being furnished for the care recipient above.

Does the care provider provide "Nursing Services" for the care recipient? Yes ☐ No ☐

DEFINITION OF NURSING SERVICES (necessary for allowing deductibility of certain costs)

(M21--1MR, Part V, Subpart iii, Chapter 1, Section G, 43) . . . "*Examples of nursing services are assisting an individual with bathing, dressing, feeding, and **other activities of daily living,***" …walking, toileting, hygiene assistance.

CARE PROVIDER -- LINE 9 ABOVE -- OFFERS THE FOLLOWING SERVICES FOR THE CARE RECIPIENT -- LINE 4 ABOVE:

ACTIVITIES OF DAILY LIVING			INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
	Yes	No		Yes	No
Provides help with getting out of bed (ADL)			Provides room and board		
Provides help with dressing (ADL)			Provides shopping services		
Provides help with bathing (ADL)			Provides emergency response staff		
Provides help with ambulating/walking (ADL)			Provides supervision and / or reminders for medications		
Provides help with toileting (ADL)			Provides housework services (cleaning, laundry, etc…)		
Provides help with incontinence (ADL)			Answers phones and / or keeps track of money and bills		
Provides help with feeding (ADL)			Provides homemaker services		
Provides supervision and properly secured living arrangements for a protected environment (ADL)			Provides meals because care recipient above is physically or mentally incapable of preparing his or her own meals		
Provides help with personal hygiene (ADL)			Provides medical or monitoring alert equipment		
Provides for frequent need of adjustment of special prosthetic or orthopedic devices (ADL)			Providing activities and an environment for necessary social stimulation		
Provides supervision to prevent person from harming self or wandering (ADL)			Physical security such as room checks, emergency pull cords, locked and/or monitored exterior doors		
Provides supervision to prevent person from harming others (ADL)			Provides transportation for doctor visits and other vital medical purposes		
Other (ADL):			Other (IADL):		

This form should be signed by the claimant and a supervisor, administrator, owner or other responsible person with the care provider. For a personal in-home attendant, the in-home attendant should sign this form.

We, the below signing persons, certify the above information is correct and true to the best of our knowledge.

Care Provider's Name & Title: _____

Care Provider 's Signature: _____

Claimant 's Signature: _____

Date Signed:_____