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) (First, Last)*

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

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

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

5. WHAT IS THE FACILITY TELEPHONE NUMBER? – –

International Phone Number *(If applicable)*

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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)*

/ /

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

/ / ☐ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$, . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, 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)*

/ /