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) (First, Last)*

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

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?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?
___ – ___ – ____

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code –

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)*
__ / __ / ____

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 HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$ ____ . __ PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
___ 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)*
__ / __ / ____