



## ATTENDANT AFFIDAVIT

RE:

\_\_\_\_\_  
Veteran's Name – Last, First Middle

\_\_\_\_\_  
VA Claim or Social Security Number

\_\_\_\_\_  
Claimant's Name

\_\_\_\_\_  
Claimant's Address (Street)

\_\_\_\_\_  
City, State and Zip Code

My name is \_\_\_\_\_, and I provide health care for the above named claimant.

The services which I provide:

- |                          |                         |                          |    |                           |
|--------------------------|-------------------------|--------------------------|----|---------------------------|
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Assistance with bathing   |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Standing and sitting      |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Getting in and out of bed |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Eating                    |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Walking                   |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Dressing and undressing   |
| <input type="checkbox"/> | Yes                     | <input type="checkbox"/> | No | Taking medication         |
| <input type="checkbox"/> | Other (Please describe) |                          |    |                           |

For these services, I am paid by the claimant \_\_\_\_\_ per day / week / month / year (please circle only one)

I began my employment on \_\_\_\_\_

\_\_\_\_\_  
Signature of provider

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, State, and Zip Code

\_\_\_\_\_  
Phone Number (including area code)

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount I listed for the services listed. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Claimant  
Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

I certify I spend the following amount of time on the following health care services for

\_\_\_\_\_  
(name of claimant)

Activities of Daily Living (ADLs):

Eating \_\_\_\_\_ hours per week

Bathing/showering \_\_\_\_\_ hours per week

Dressing \_\_\_\_\_ hours per week

Transferring (for example: from bed to chair) \_\_\_\_\_ hours per week

Using the toilet \_\_\_\_\_ hours per week

Instrumental Activities of Daily Living (IADLs):

Shopping \_\_\_\_\_ hours per week

Food preparation \_\_\_\_\_ hours per week

Housekeeping \_\_\_\_\_ hours per week

Laundry \_\_\_\_\_ hours per week

Managing finances \_\_\_\_\_ hours per week

Handling medication \_\_\_\_\_ hours per week

Using the telephone \_\_\_\_\_ hours per week

Transportation for non-medical purposes \_\_\_\_\_ hours per week

Other (explain): \_\_\_\_\_ hours per week

Other (explain): \_\_\_\_\_ hours per week

Other (explain): \_\_\_\_\_ hours per week

\_\_\_\_\_  
Signature of in-home attendant

\_\_\_\_\_  
Date