FACILITY CERTIFICATION

Name of facility: ______________________________

Address of facility: ______________________________

____

Telephone Number: ______________________________

Name of Veteran ______________________________

Name of Claimant ______________________________

Claim/SSN ______________________________

Date entered facility: ______________________________

Cost per month for lodging/meals: $__________

Cost per month for medical services/custodial care $__________

Total monthly charges $__________

Signature of Certifying Official ______________________

Title of Certifying Official ______________________

Date ______________________