IN-HOME ATTENDANT CERTIFICATION

Name of Attendant: ____________________________

Telephone Number: ____________________________

Name of Veteran ____________________________

Name of Claimant ____________________________

Claim/SSN ____________________________

Cost per month for health care/ADL assistance $____________

Cost per month for assistance with IADLs $____________

Cost per month for custodial care $____________

Total monthly charges $____________

This is to certify that I receive $____________ from the above named veteran/claimant for in-home assistance and care.

Signature of provider ____________________________

Date ____________________________