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: _____