



Eff. 8/2000

TEXAS VETERANS COMMISSION

ASSISTED LIVING STATEMENT

Name of veteran must be provided whether statement is completed for veteran or for widow.

RE: _____
Name of Veteran

Claim # or SSN

Name of Assisted Living Facility

Name of Claimant

Address

Date of Admission

Telephone Number

Claimant's Mailing Address

License Number

City State Zip

STATEMENT OF CHARGES

Amount of Recurring Gross Daily Charges for Assisted Living Care \$ _____

Amount paid and not reimbursed *\$ _____

CLAIMANT CERTIFICATION

*I certify the amount as identified above is being paid from personal funds. These expenses are paid out of my pocket without reimbursement from any source. I request this amount be used as a continuing deduction from my countable income.

Signature of Witness**

Signature of Claimant

Signature of Witness**

**NOTE: If claimant signs with his/her mark, the mark must be witnessed by two witnesses.

STATUS OF CLAIMANT:

Patient requires assistance? _____ or a residence (needs dwelling)? _____

Disabilities Requiring assistance: _____

Level of Care _____

ADDITIONAL REMARKS:

Is Claimant eligible for Medicare? _____

Date Signed

Signature of Assisted Living Facility Administrator or Agent