

VETERANS PENSION BENEFITS 2025

Our staff of VA trained and accredited County Veteran Service Officers can answer your questions, assist in completing the necessary VA forms, and act as the veteran’s advocate through the claim process.

ALL SERVICES ARE PROVIDED FREE OF CHARGE.

LAKE COUNTY VETERANS SERVICE OFFICE

An Office of Lake County Government
Located in Building C of the Lake County Administration Center

105 Main St.,
Painesville, OH 44077
(440) 350-2904/2567
Fax (440) 350-5980



If you are a veteran whose disabilities prevent employment or overwhelmed with the high cost of medical care, such as paying for assisted living facilities, home care aides, adult daycare, or skilled nursing, the VA Pension benefit could be the solution to help pay for this care. A wartime veteran with limited income and net worth may be eligible to receive this benefit.

There are three levels of VA Pensions:

- Basic Pension**—for veterans who are disabled **OR** age 65 or older with low income
- Aid & Attendance (A&A)** – for veterans that require assistance with their activities of daily living
- Housebound** – for veterans with a permanent disability that prevents them from leaving their home.

You may be eligible if:

- you were discharged from military service under other than dishonorable conditions; **AND**
- you served 90 days of active duty or more with at least 1 day during a war time period*; **AND**
- your annual household income and net worth** meet certain limits set by law; **AND**
- you are permanently and totally disabled, **OR** age 65 or older.

*To find the dates of service considered as war time periods, visit: www.va.gov/pension/war-time-period. Veterans who enlisted after September 7, 1980 generally must have served at least 24 months of active duty OR the full period for which called or ordered to active duty.

PENSION RATES effective 12/1/2024	MAXIMUM MONTHLY BENEFIT	(MAPR)MAXIMUM ANNUAL
Basic Pension with no dependents	\$1,414.00	\$16,965.00
Basic Pension with 1 dependent	\$1,851.00	\$22,216.00
With Housebound benefits with no dependents	\$1,727.00	\$20,732.00
With Housebound benefits with one dependent	\$2,165.00	\$25,982.00
With Aid and Attendance with no dependents	\$2,358.00	\$28,300.00
With Aid and Attendance with one dependent	\$2,795.00	\$33,548.00
Veteran in Nursing Home receiving Medicaid benefits	\$90.00	N/A

****OUT OF POCKET MEDICAL EXPENSES PAID BY THE HOUSEHOLD ARE USED TO REDUCE THE HOUSEHOLD INCOME.** You may deduct only the amount that’s above 5% of your MAPR amount . Please see the examples on page 2.

*****HOUSEHOLD NET WORTH LIMIT MUST BE UNDER \$159,240.00**

(as of 12/01/2024 –changes annually) Net worth is the sum of household assets and annual income. It does NOT include a primary residence and lot under 2 acres, automobile, or personal effects. As of 10/18/2018 the VA instituted a “look back” period of 3 years. Any assets transferred to reduce net worth in the last 3 tax years must be reported and may prohibit qualifying for the pension benefit for up to 5 years.

DETERMINING THE MONTHLY BENEFIT AMOUNT:

The amount of the possible benefit can be determined by totaling the amount of monthly GROSS household income and then subtracting the monthly total of continuing out of pocket medical expenses which equals the countable income. The countable income is then subtracted from the maximum monthly income limit for the veteran's situation. (See the chart on page 1.) The examples below can help you to understand how the VA calculates the amount. All amounts are monthly figures.

The Pension Worksheet on page 3 can be used to determine the possible benefit.

1. PENSION EXAMPLE:

The veteran is an 85-year-old Korean War veteran. His only source of income is \$800.00 (GROSS) in Social Security (SS) benefits. He is still able to care for himself in his home which is paid off. He has no savings or any other assets. Medicare Part B is withheld from his SS benefit and he also pays for a supplemental health insurance.

Medical Expenses:	Gross Income:	Possible Benefit:
Medicare Part B \$185.00	SS \$950.00	VA Max. Monthly Limit \$1,414.00
Health Insur <u>200.00</u>	Less med exps <u>385.00</u>	Less countable income <u>600.00</u>
Total med exps \$385.00	Countable inc \$600.00	VA Pension benefit \$814.00

2. PENSION WITH AID AND ATTENDANCE EXAMPLE:

The veteran is 75 years old and a veteran of the Vietnam era. He receives Railroad Retirement (RR) and a pension from an employer. Medicare Part B is withheld from his RR benefit and health insurance is withheld from his pension. His only asset is a savings account with \$60,000.00. He is living in an assisted living facility because his doctor has stated he can no longer live on his own but doesn't yet require nursing home care.

Medical Expenses:	Gross Income:	Possible Benefit:
Medicare Part B \$185.00	RR \$1,500.00	VA Max. Monthly Limit \$2,358.00
Health Insur 200.00	Pension <u>700.00</u>	Because the veteran's income is less than
Assisted Living <u>4,500.00</u>	Total income \$2,200.00	his medical expenses, his countable income
Total med exps \$4,885.00	Less med exps <u>4,885.00</u>	is zero. He would receive the full benefit
	Countable inc 0.00	of \$2,358.00 .

3. NURSING HOME WITH MEDICAID EXAMPLE:

The veteran in example #1 becomes ill and must now be placed in a nursing home. Medicaid pays for his care and he receives just a small amount of his SS benefit. The VA Pension benefit will be reduced to **\$90.00** per month which can be used for his personal needs such as clothing, etc.

4. VETERAN WHOSE WIFE REQUIRES AID AND ATTENDANCE EXAMPLE:

The veteran served in the Korean War and in good health. His wife has been diagnosed with several disabilities and the veteran cannot care for her at home. She resides in an assisted living facility. Their combined net worth is \$100,000.00. The gross income and countable medical expenses for both the veteran and spouse are reported.

Medical Expenses:	Gross Income:	Possible Benefit:
Assisted Living \$6,000.00	Vet-SS \$1,100.00	VA Max. Monthly Limit \$1,851.00*
Medicare Part B 370.00*	Wife-SS 550.00	Because the household income is less than
Health Insur <u>250.00</u>	Wife-Pension <u>200.00</u>	the medical expenses, the countable
Total med exps \$6,620.00	Total income \$1,850.00	is zero. He would receive the full benefit of
	Less med exps <u>6,620.00</u>	\$1,851.00 . *The veteran does not require
	Countable inc 0.00	aid and attendance so the higher rate of

*(185.00 X 2 for veteran and wife)

VA PENSION WORKSHEET * This worksheet helps to determine only a **POSSIBLE** VA benefit amount.
 All claims for benefits must be processed through the VA to determine eligibility and benefit amount.
 PLEASE PROVIDE STATEMENTS DOCUMENTING ALL AMOUNTS.

GROSS MONTHLY INCOME	VETERAN	SPOUSE	OTHER DEPENDENT	SOURCE
SOCIAL SECURITY				
US CIVIL SERVICE				
RAILROAD RETIREMENT				
BLACK LUNG BENS				
ANY RETIREMENT OR PENSIONS				
SSI/PUBLIC ASSISTANCE				
LONG TERM CARE INSUR BENEFITS RECEIVED				
WAGES FROM EMPLOYMENT				
OTHER (PROVIDE SOURCE)				
OTHER (PROVIDE SOURCE)				
OTHER (PROVIDE SOURCE)				
TOTALS			(A)	

TOTAL HOUSEHOLD INCOME(A) []
LESS TOTAL HOUSEHOLD MEDICAL EXPENSES (B) []
EQUALS COUNTABLE INCOME (C) []
 If household income is less than medical expenses, the countable income is "0"
VA INCOME LIMIT for your situation
 (from pg 1-i.e. veteran w/aid & attendance is \$2,050.00)
LESS COUNTABLE INCOME(C) []
 (from above)
EQUALS POSSIBLE* VA BENEFIT []

CONTINUING **		TOTAL HOUSEHOLD INCOME	
MONTHLY MED EXPENSES	VETERAN	SPOUSE	OTHER DEPENDENT
ACCOUNT	CURRENT BALANCES		
MEDICARE PART B			
HEALTH INSUR PREMIUM			
HEALTH INSUR PREMIUM			
RX INSUR PREMIUM			
NURSING HOME			
ASSISTED LIVING			
HOME HEALTH AIDES			
LONG TERM CARE INSUR PREMIUMS PAID			
OTHER (PROVIDE TYPE)			
OTHER (PROVIDE TYPE)			
TOTALS ** List only medical expenses which are the same every month (B)			
**TOTAL NET WORTH MUST BE UNDER \$155,356.00			

TOTAL HOUSEHOLD MEDICAL EXPENSES []
ADDRESS: []
DO YOU OWN A HOME? []
IS THERE ANY RENTAL INCOME? []

CHECKLIST OF DOCUMENTATION NEEDED TO COMPLETE THE VA FORMS FOR PENSION:

The average processing time for VA Pension is an average of 6 to 9 months. Therefore, it is best to submit all supporting documentation with the original claim forms to expedite the process as much as possible.

FAILURE TO PROVIDE ALL DOCUMENTATION WILL DELAY THE FILING OF THE CLAIM AND A DECISION FROM THE VA.

___ **DD 214/Military Separation Record.** We can assist with obtaining this document if necessary or you can request it FREE OF CHARGE on-line at: www.archives.gov/veterans/military-service-records.

___ **Social Security numbers for veteran and dependents.** Please also provide VA Claim number if available.

___ **Marriage Licenses and Death Certificates.**

___ **Proof of all income.** Please provide statements showing the **GROSS* amounts** (before any deductions such as Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from investments, rental or business income, long term care insurance benefits received, etc. *This amount can generally be found on annual statements from Social Security and other benefits.

___ **Current statements for all assets.** All checking, savings accounts, stocks, bonds, mutual funds, all trusts, annuities, long term care insurance, savings bonds, etc.

___ **Direct Deposit account information and/or voided check.**

___ **Documentation regarding any transfer of assets you or your dependents have made in the last 3 tax years.** Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust.

___ **Amounts of CONTINUING monthly medical expenses.** When initially filing for the VA Pension benefit, we will report household "out of pocket" medical expenses which are the same every month. These include:

- Medicare deductions withheld from Social Security or other benefits for Parts B, C, or D.
- Supplemental insurance premiums for health, dental, prescriptions, vision plans, etc. (sometimes withheld from pension/retirement benefits)
- Prescriptions/over the counter medications/medical supplies (i.e. incontinence supplies) which are the same every month
- Long term care insurance premiums
- Final funeral/burial expenses paid by the veteran for spouse in the last year
- Amounts paid for in home health care, adult day care, assisted living, and nursing home (SEE BELOW)

___ **Documentation from the Ohio Department of Jobs and Family Services (ODJFS) regarding Medicaid.**

___ **Any Guardianship Appointments or Power of Attorneys.**

If the claimant is in a Nursing Home:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician **AND** signed by the veteran/claimant. If both the veteran and spouse require care, please have a form completed for each. **AND**

___ **VA Form 21P-0779 included in this packet** (Request for Nursing Home Information) Completed by Nursing Home

If the claimant is in an Assisted Living, Adult Day Care, or similar facility:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require care, please have a form completed for each. **AND**

___ **VA Form 21P-527EZ, page 16 included in this packet** (Worksheet for an Assisted Living, etc.) Completed by the facility.

If the claimant receives medical care from an In-Home Care Attendant:

___ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require care, please have a form completed for each. **AND**

___ **VA Form 21P-527EZ, page 17 included in this packet** (Worksheet for an In-Home Care, etc.) Completed by In-Home Attendant. Complete a Worksheet for each paid In-Home Attendant.

ETERAN'S SOCIAL SECURITY NUMBER

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SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

- YES (If "YES," complete Items 14B, 14C & 14D)
 NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

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14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)

15B. DATE SIGNED (MM/DD/YYYY)

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**SECTION VI: EXAMINATION INFORMATION
 (IMPORTANT: Remainder of form MUST be filled out by Examiner)**

NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

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NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.		D.	
B.		E.	
C.		F.	

19A. AGE

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19B. WEIGHT

ACTUAL LBS.

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 ESTIMATED LBS.

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19C. HEIGHT

FEET

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 INCHES

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20. NUTRITION

21. GAIT

22. BLOOD PRESSURE

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23. PULSE RATE

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24. RESPIRATORY RATE

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25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

VETERAN'S SOCIAL SECURITY NUMBER - -

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- BATHING/SHOWERING TENDING TO HYGIENE NEEDS ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
 EATING OR SELF-FEEDING TRANSFERRING IN OR OUT OF BED/CHAIR
 DRESSING TOILETING
 AMBULATING WITHIN THE HOME OR LIVING AREA MEDICATION MANAGEMENT

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- YES
 NO

28B. CORRECTED VISION

LEFT EYE

RIGHT EYE

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

- YES
 NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- YES
 NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (NOTE: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

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3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

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4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

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5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

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6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

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7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table>		/		/					12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table> <input type="radio"/> INDEFINITE		/		/				
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13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

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 PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the care recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table>		/		/				
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WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

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2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider)*

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3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO *(If "NO," skip to question 7)*

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

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6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

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Apt./Unit Number

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 City

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State/Province

--

 Country

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 ZIP Code

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT.
(MM/DD/YYYY)

	/		/	
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12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
(Select "Indefinite" if the care you provide is not temporary.)

	/		/		<input type="radio"/> INDEFINITE
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13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

\$

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 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

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 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER *(From question 2)*

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16. DATE SIGNED *(MM/DD/YYYY)*

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