## CLAIMANT REPORTS CHANGE IN CARE FACILITY

You reported you have changed care providers. In order to count expenses paid to your new care provider, we need more information about this change. On the enclosed VA Form 21-4138 (Statement in Support of Claim), please provide the following:

- The date your prior home care stopped OR the date you left your prior facility.
- The total amount you paid your prior care provider during [insert the year in which they left the facility or home care stopped].

In addition, please have your new care provider answer the following questions. **Please note that both you and the administrator of your facility/your care provider must sign and date the last section, or we will NOT be able to consider these expenses.**

Veteran's name: _____

Patient's name: _____

Name of facility or care provider: _____

Phone number of facility or care provider: _____

Address of facility or care provider: _____

_____

_____

Date entered facility or in-home care began: _____

Date patient left facility (if applicable): _____

Will the patient need this care indefinitely? Yes____ No____

If No, when will the care end? _____

Has the patient applied for Medicaid? Yes____ No____

Is part of the patient's cost covered by Medicaid, Medicare, or insurance? Yes____ No____

When did coverage begin? _____

What monthly amount does the veteran or patient pay from his/her own funds?

Effective date: _____ $_____ per month

(prior) Effective date: _____ $_____ per month

**SIGNATURES:**

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____

**Signature of Facility Administrator or Care Provider** **Date**

**I certify that the above statements are true and correct to the best of my knowledge and belief.**

_____

**Signature of 3rd party contractor (if applicable)** **Date**

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_____ per month for my care from my own funds.

_____

**Signature of Veteran or Beneficiary** **Date**