



Rev. 8/2000

TEXAS VETERANS COMMISSION

NURSING HOME 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 Nursing Home

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 Nursing 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:

Is claimant a patient (needs nursing care)? _____ or a Resident (needs dwelling)? _____

Disabilities Requiring Nursing Home Care: _____

Level of Care _____

ADDITIONAL REMARKS: (Please provide explanation if care is other than Skilled or Intermediate)

Is Claimant eligible for Medicare? _____ or Medicaid Benefits? _____ If Medicaid, effective date _____

Date Signed

Signature of Nursing Home Administrator or Agent