TVC 15b

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 Witness**

_____
Signature of Claimant

**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