STATEMENT AS TO LEVEL AND COST OF CARE
TO BE COMPLETED BY ASSISTED LIVING FACILITY

This information is requested for the purpose of determining the medical level of care the claimant requires. The cost of that medical care is used by the VA to determine if expenses are allowed for maximum benefits.

Last Name	First Name	MI	SSN

Name of Assisted Living Facility	Date of Admission

Address of Assisted Living Facility (City, State, ZIP)	Telephone Number

Level of Care *(Please mark with an X)*	**X**
Level 1 (Room and Board Only)	
Level 2 (Room and Board plus medical assistance)	
OTHER (Please Explain)	

The Activities of Daily Living (ADLs) provided to the resident are as follows *(please mark with an X)*

Services Provided	X	Services Provided	X
Provides help getting out of bed		Provides help with feeding	
Provides help with dressing		Provides help with personal hygiene	
Provides help with bathing		Provides frequent need of adjustment of prosthetic/ orthopedic devices	
Provides help with ambulating/ walking		Provides supervision to prevent person from harming self, falling, or wandering	
Provides help with toileting		Provides supervision to prevent person from harming others	
Provides help with incontinence		Provides supervision and properly secured living arrangements for a protected environment	

Total Monthly Charges for Room, Board, and Medical Fees for services provided	$

Assisted Living Facility Administrator's name (printed)	Email Address

Administrator's Signature	Date	Telephone Number