ATTENDANT AFFIDAVIT
TO BE COMPLETED BY CAREGIVER

This information is requested for the purpose of determining Pension with Aid and Attendance Benefits based on medical expenses.

_____   _____   _____

Claimant Last Name   Claimant First Name   Claimant SSN

_____   _____

Name of Person/ Company providing Healthcare services   Telephone Number

_____   _____

Address of Person/ Company providing Healthcare services   Date Services Began

The services I provide are as follows (please mark with an X)

Activities of Daily Living (allowable medical expenses)	X	Instrumental Activities of Daily Living (does not count as standalone medical expenses)	X
Provides help getting out of bed		Provides room and board	
Provides help with dressing		Provides shopping services	
Provides help with bathing		Provides emergency response staff	
Provides help with ambulating/ walking		Provides medication supervision and/ or reminders	
Provides help with toileting		Provides housework services (cleaning, laundry, etc…)	
Provides help with incontinence		Provides respite services for spouse	
Provides help with feeding		Provides homemaker services	
Provides help with personal hygiene		Provides medical or monitoring alert equipment	
Provides frequent need of adjustment of prosthetic/ orthopedic devices		Provides activities and an environment for necessary social stimulation	
Provides supervision to prevent person from harming self, falling, or wandering		Physical security such as room checks, emergency pull cords, locked and/ or monitored exterior doors	
Provides supervision to prevent person from harming others		Provides transportation for doctor visits and other vital medical purposes	
Provides supervision and properly secured living arrangements for a protected environment		Provides meals because care recipient above is physically or mentally incapable of preparing them	
Other:		Other:	

For these Services, I am paid by the claimant $ _____ per month.

$Per Hour _____ Hours per day _____ #days per week _____

_____   _____   _____

Caregiver's name (printed)   Caregiver's Signature   Date

_____   _____   _____

Claimant's name (printed)   Claimant's Signature   Date

Revised 09-2019