ATTENDANT AFFIDAVIT

RE: _____
Veteran's Name

_____
VA Claim # or Social Security Number

_____
Name of Claimant

_____
Address

_____
City State Zip

My name is _____, and I provide health care for the above named claimant.

The services I provide are (please circle answer):

Assistance with Bathing	Yes	No
Standing and Sitting	Yes	No
Getting in & out of bed	Yes	No
Eating	Yes	No
Walking	Yes	No
Dressing & Undressing	Yes	No
Taking Medication	Yes	No

Other (please describe) _____

_____

_____

For these services, I am paid by the claimant _____ per day / week / month / year. (please circle only one)

I began employment on _____

_____
Signature of provider

_____
Street Address

_____
City, State, and Zip Code

_____
Phone Number (including area code)

I certify, under the penalty of law, that the above information is true and correct, that I do pay the above referenced attendant the amount listed for the services listed. (If the claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature _____ Date _____

Witness _____ Date _____

Witness _____ Date _____