

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

- (1) Eating
- (2) Bathing/Showering
- (3) Dressing
- (4) Transferring (for example, from bed to chair)
- (5) Using the toilet

Custodial Care is regular -

- assistance with two or more ADLs, **or**
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

YES NO (If "NO," continue to Step 2)
(If "YES," all payments to the facility qualify as medical expenses in Items 30A - 30F. You are finished completing this worksheet)

STEP 2. Do **all** of the following apply to the facility?

- The facility is licensed (if the State or Country requires it)
 - The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
 - If the facility is residential, it is staffed 24 hours per day with caregivers
- YES NO (If "NO," payments to the facility **do not** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the veteran) the disabled person?

YES NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

YES NO (If "NO," payments to this facility for meals and lodging **do not** qualify as medical expenses. **Only** claim amounts you pay the facility for **health care services or assistance with ADLs provided by a health care provider** in Items 30A - 30F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the **primary reason** you live in the facility (or attend day care in the facility)?

YES NO (If "YES," all payments to this facility **may** qualify as medical expenses **if** VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) **lodging and meals**, (2) **health care services or assistance with ADLs provided by a health care provider**, and (3) **custodial care**. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

YES NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)
(If "NO," claim payments you pay this facility for **health care services or assistance with ADLs provided by a health care provider** in Items 30A - 30F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the **primary reason** the disabled person lives in the facility (or attends day care in the facility)?

YES NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 30A - 30F)
(If "NO," **only** claim payments you pay the facility for assistance with **health care and/or assistance with custodial care** as medical expenses in Items 30A - 30F. Payment to this facility for meals and lodging **do not** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received. **I CERTIFY** that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and

reflects the current environment pertaining to _____
(Name of person staying at facility)

and his or her care at this facility _____
(Name and address of facility)

(Name, Signature and Title of Person Certifying for the Facility)

(Date Certified)