NURSING HOME STATUS STATEMENT

This is to certify that ____________________________________ has been a patient receiving
(name)

_____________________________ level of care at _________________________________
(level of care) (facility name)

since _____________ because of ____
(date) (diagnosis of major conditions)

____

____

____

and need for such care is considered to be permanent.

Is the claimant considered mentally capable of handling their own affairs? ☐ YES ☐ NO

____
Signature of Nursing Home Physician or Private Practitioner

If State Assisted, please show the effective date of Medicaid/State Assistance eligibility: ____________.

Please show the claimant's nursing home expenses with a breakdown of how these expenses will be paid. If the answer is "None", enter zero.

Out-of-Pocket expenses paid by claimant: $__________________

Medicaid: $____________________

Insurance: $___________________

Other: $______________________

____
Signature of Administrator

____
Name of Nursing Home Facility

____
Address Line 1 of Nursing Home Facility

____
Address Line 2 of Nursing Home Facility

I hereby certify that the above is true to the best of my knowledge and belief.

____
Signature of Claimant