CARE PROVIDER CERTIFICATION OF SERVICES (FORM FV13)

Instructions for Filling out this Form

The purpose of this form is to provide the Department of Veterans Affairs (VA) with detailed information about the types of care support services you (the care provider) are currently providing the claimant (i.e. a veteran, the veteran's unhealthy spouse, or the surviving spouse of a veteran who is applying for a benefits). Please complete pages one and two of this form.

The claimant and the care provider supervisor or facility administrator must sign this form.

VA's Use of the Term "Medical Services"
VA uses the terms "Medical Services" and "Nursing Services" interchangeably. Below is a list of some Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Generally, services for care and a need for care involving two or more of ADLs are necessary for the claimant's ongoing care costs to be considered unreimbursed medical expenses (UMEs).

- Help with getting in and out of bed / transferring (ADL)
- Help with dressing (ADL)
- Help with ambulating / walking (ADL)
- Help with bathing / showering (ADL)
- Help with feeding (ADL)
- Help with toileting (ADL)
- Help with incontinence (ADL)
- Help with personal hygiene (ADL)
- Help with prosthetic adjustments (ADL)
- Close supervision to prevent injury, wandering, or falls (ADL)
- Preparing and serving meals (IADL)
- Providing room and board (IADL)
- Doing housework and laundry (IADL)
- Supervising or providing reminders for medication (IADL)
- Providing transportation (IADL)
- Help with answering the telephone (IADL)
- Help with keeping track of money and paying bills (IADL)
- Secured living arrangements and emergency pull cords (IADL)

Protected Environment
"Protected Environment" means professional services in a daily living arrangement for adults who are experiencing a decrease in physical or mental or social functioning and require direct supervision and support. A person requiring a protected environment could not function by himself or herself without this need for support. This daily living arrangement can be in a home or in a facility.

VA often requires a care provider to certify that the claimant is being cared for in a Protected Environment. Page two of this report will give you the opportunity to provide VA with evidence that the claimant's Protected Environment needs are being met. They will use this information to base a decision on the claimant's need for care and application for benefits.

Line 1. Name of Person Receiving Care Services

This person can either be the veteran or the non-veteran spouse of the veteran. This person can also be the single surviving spouse of a veteran.

Line 2. Name of Veteran (For VA Purposes)

This must always be the name of the veteran whether the veteran is living or dead.

Line 3. Veteran Social Security Number or VA Case (Claim) Number

This must always be the Social Security Number of the veteran whether living or dead. As a general rule, with new applications, there is no VA case (claim) number. It would only exist if the veteran or the surviving spouse had previously made a claim to VA.

Line 9. Name of Care Service Provider

This is the name of the assisted living facility, board and care, adult day, home care company or private in-home attendant.

Line 10. Complete Address and Phone Number of the Care Service Provider

This is the address and phone number of the assisted living facility, board and care, adult day, home care company or private in-home attendant. Please know that VA will likely contact you before they make a decision on the claimant's application. VA will ask questions about the care you are providing the claimant and if monthly payments for care have been and will continue to be made. Generally, a claimant is not eligible for benefits if payments for care are reduced or cease.

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1. Name of Person Receiving Care Services	2. Name of Veteran (For VA Purposes)		3. Veteran Social Security Number or VA Case Number	
4. Address of Person Receiving Care Services	5. City	6. State	7. Zip	8. Phone(s) and email
9. Name of Care Service Provider	10. Complete Address and Phone Number of the Care Service Provider			

Check the appropriate box below for the type of service offered by the care provider.

Residential Care Facility ☐
Assisted Living ☐
Professional Home Care Company ☐
Nursing Home ☐
Adult Day (Care) Service ☐
Private In-Home Attendant ☐
Adult Foster Care ☐
Adult Family Home ☐

If care provider provides 24-hour permanent residence for the care recipient, fill in the information below.

Date service started ___________________________

Monthly charges including room and board, extras and care services $______________________

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider anticipates the need for services will continue month-to-month. Yes___ No___

Care provider provides a "protected environment" for the care recipient. Yes___ No___

If care provider offers assistance during the day at a location other than the care recipient's home, fill in below.

Date service started ___________________________

Number of hours per day of service _______________

Number of days per week of service ______________

Care provider anticipates the need for services will continue month-to-month. Yes___ No___

Monthly charges including meals, site-to-site transportation and care services $_______________________

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider provides a "protected environment" for the care recipient. Yes___ No___

If care provider offers assistance in the home of the care recipient or in the home of someone else, fill in below.

Date service started ___________________________

Number of hours per day of service _______________

Number of days per week of service ______________

Care provider anticipates the need for services will continue month-to-month. Yes___ No___

Please attach a copy of the care provider contract.

Monthly charges including meals, transportation, housework and care services $______________________

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid.")

Care provider provides a "protected environment" for the care recipient. Yes___ No___

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COMPLETE THIS SECTION FOR ASSISTED LIVING, HOME CARE, ADULT DAY CARE, NURSING HOME, IN-HOME ATTENDANT, etc

Please describe briefly the "**protected environment**" and/or care services being furnished for the care recipient above.

Does the care provider provide "Nursing Services" for the care recipient? Yes ___ No ___

DEFINITION OF NURSING SERVICES (necessary for allowing deductibility of certain costs)

(M21--1MR, Part V, Subpart iii, Chapter 1, Section G, 43) . . . "*Examples of nursing services are assisting an individual with bathing, dressing, feeding, and* ***other activities of daily living,***" …walking, toileting, hygiene assistance.

CARE PROVIDER -- LINE 9 ABOVE -- OFFERS THE FOLLOWING SERVICES FOR THE CARE RECIPIENT -- LINE 4 ABOVE:

ACTIVITIES OF DAILY LIVING	Yes	No	INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Yes	No
Provides help with getting out of bed (ADL)			Provides room and board		
Provides help with dressing (ADL)			Provides shopping services		
Provides help with bathing (ADL)			Provides emergency response staff		
Provides help with ambulating/walking (ADL)			Provides supervision and / or reminders for medications		
Provides help with toileting (ADL)			Provides housework services (cleaning, laundry, etc…)		
Provides help with incontinence (ADL)			Answers phones and / or keeps track of money and bills		
Provides help with feeding (ADL)			Provides homemaker services		
Provides supervision and properly secured living arrangements for a protected environment (ADL)			Provides meals because care recipient above is physically or mentally incapable of preparing his or her own meals		
Provides help with personal hygiene (ADL)			Provides medical or monitoring alert equipment		
Provides for frequent need of adjustment of special prosthetic or orthopedic devices (ADL)			Providing activities and an environment for necessary social stimulation		
Provides supervision to prevent person from harming self or wandering (ADL)			Physical security such as room checks, emergency pull cords, locked and/or monitored exterior doors		
Provides supervision to prevent person from harming others (ADL)			Provides transportation for doctor visits and other vital medical purposes		
Other (ADL):			Other (IADL):		

This form should be signed by the claimant and a supervisor, administrator, owner or other responsible person with the care provider. For a personal in-home attendant, the in-home attendant should sign this form.

We, the below signing persons, certify the above information is correct and true to the best of our knowledge.

Care Provider's Name & Title: ______________________________________

Care Provider 's Signature: ______________________________________

Claimant 's Signature: ____

Date Signed:__________________