

CARE PROVIDER CERTIFICATION OF SERVICES (FORM FV13)

Instructions for Filling out this Form

A Care Provider Supervisor or Facility Administrator must complete and sign this document. VA will likely contact this person to verify this information

Purpose of 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 VA Benefit). Please complete this form in its entirety.

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 is necessary for the claimant to be awarded a benefit from VA.

- Help with getting out of bed (ADL)
- Help with dressing (ADL)
- Help with ambulating / walking (ADL)
- Help with bathing (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 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)

In addition, VA may also be asking if you really do offer traditional nursing services with an in-house or visiting RN or LPN or social worker or physical therapist. These services would also be applicable as VA deductible "medical services."

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 or indirect supervision and support.

This report is crucial for proving the claimant's need for a Protected Environment. VA often requires a care provider to certify that the claimant is being cared for in a Protected Environment and / or is receiving ongoing personal care from others. This report will 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 application for Pension or Death Pension. Such support might include one or more of the following:

- monitoring,
- room checks,
- medication reminders,
- managing medications,
- help with activities of daily living such as bathing, dressing, walking, toileting, etc...
- availability of aides,
- medical alert systems,
- secure living conditions,
- help making financial decisions,
- laundry services,
- housekeeping,
- provider strategies to prevent wandering,
- social activities,
- strategies to provide social stimulation,
- preparation of meals,
- strategies to prevent falling, and
- transportation.

A person requiring a protected environment could not function by himself or herself without this need for support. The daily living arrangement can be in a home or in a facility.

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 a 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 Number

This must always be the Social Security Number of the veteran whether living or dead. As a general rule, with these types of applications, there is no VA case 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.

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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 Care Service Provider			

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

- | | | |
|--|---|---|
| Residential Care Facility <input type="checkbox"/> | Assisted Living <input type="checkbox"/> | Professional Home Care Company <input type="checkbox"/> |
| Nursing Home <input type="checkbox"/> | Adult Day (Care) Service <input type="checkbox"/> | Private In-Home Attendant <input type="checkbox"/> |
| Adult Foster Care <input type="checkbox"/> | Adult Family Home <input type="checkbox"/> | |

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

Date service started _____	Care provider anticipates the need for services will continue month-to-month. Yes___ No___
Monthly charges including room and board, extras and care services \$ _____	Care provider provides a "protected environment" for the care recipient. Yes___ No___
Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."	

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

Date service started _____	Monthly charges including meals, site-to-site transportation and care services \$ _____
Number of hours per day of service _____	Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."
Number of days per week of service _____	Care provider provides a "protected environment" for the care recipient. Yes___ No___
Care provider anticipates the need for services will continue month-to-month. 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 _____	Monthly charges including meals, transportation, housework and care services \$ _____
Number of hours per day of service _____	Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."
Number of days per week of service _____	Care provider provides a "protected environment" for the care recipient. Yes___ No___
Care provider anticipates the need for services will continue month-to-month. Yes___ No___	
Please attach a copy of the care provider contract.	

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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**. . . ."

DEFINITION OF "OTHER ACTIVITIES OF DAILY LIVING" (ADL's and IADLs):

According to the US government Census Bureau at http://www.census.gov/hhes/www/disability/disab_defn.html, ADLs and IADLs are defined as "Had difficulty with one or more activities of daily living (the ADL's included getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting); Had difficulty with one or more instrumental activities of daily living (the IADL's included going outside the home, keeping track of money and bills, preparing meals, doing light housework, taking prescription medicines in the right amount at the right time, and using the telephone);"

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 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.

Date Signed: _____ **Title of Person Signing the Form:** _____

I, the above signing person, certify the above information is correct and true to the best of my knowledge.

Person's Name: _____ **Person's Signature:** _____