ATTENDANT AFFIDAVIT

Re: _____
Veteran's Name – Last, First, Middle

_____
VA Claim or Social Security Number

_____
Claimant's Name

_____
Claimant's Address (Street)

_____
City, State and Zip Code

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

The services which I provide are:

○ Yes	○ No	Assistance with bathing	○ Yes	○ No	Walking
○ Yes	○ No	Standing and sitting	○ Yes	○ No	Dressing and undressing
○ Yes	○ No	Getting in and out of bed	○ Yes	○ No	Taking medication
○ Yes	○ No	Eating			

○ Other: (Please describe)

_____

_____

_____

For these services, I am paid by the claimant $_____ per ○ week ○ month ○ year (select 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 sitter the amount listed for the services listed.

Signature: _____ Date: _____

(If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Witness: _____ Date: _____

Witness: _____ Date: _____