ATTENDANT AFFIDAVIT

Re:

Veteran's Name – Last, First, Middle

VA Claim or Social Security Number ______________________

____
Claimant's Name

____
Claimant's Address (Street)

____
State and Zip Code City,

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 Standing and sitting
- ☐ Yes ☐ No Getting in and out of bed
- ☐ Yes ☐ No Eating
- ☐ Yes ☐ No Walking
- ☐ Yes ☐ No Dressing and undressing
- ☐ Yes ☐ No Taking medication
- ☐ Other: (Please describe)

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____

For these services, I am paid by the claimant ____________ per day / week / month / year (please circle 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. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature: ______________________ Date: ______________________

Witness: ______________________ Date: ______________________

Witness: ______________________ Date: ______________________