Department of Veterans Affairs

Statement of Occupancy

RE: Mr./Mrs.: _____

Name of Facility: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Dear Department of Veterans Affairs:

This statement is to inform you that the above named individual is a patient/resident at our nursing home/assisted living facility.

Date Admitted to Facility: _____

Diagnosis: _____

_____

_____

Level of Care Provided: ❑ Skilled ❑ Intermediate

Does Medicaid Pay For Any Portion of Their Care?: ❑Yes ❑ No

Private Pay: ❑ Yes ❑ No

Daily Cost: _____

Is Patient Responsible for All Daily Charges?: ❑ Yes ❑ No

Please contact us if you would like additional information regarding the above.

_____ _____

Facility Representative's Name (printed) Title

_____ _____

Facility Representative's Signature Date