Department of Veterans Affairs

AGREEMENT TO PROVIDE HOME CARE FOR PATIENT

1. NAME OF VA STATION	2. ADDRESS	3. TELEPHONE NO.

4. NAME OF PATIENT	5. SOCIAL SECURITY NO.	6. CLAIM NO.

7. NAME OF PATIENT'S PHYSICIAN	8. NAME OF SOCIAL WORKER

9. AGREE TO CARE FOR THE PATIENT AT THE MONTHLY RATE OF	10. DATE WILL ACCEPT THE PATIENT INTO MY HOME

AGREEMENT: I, the undersigned, agree to accept the above named patient into my home on the date indicated in Item No. 10 at the monthly rate shown in Item No. 9. I will provide the patient with room, board, laundry service, and look after his personal welfare.

I understand that the patient will be on trail visit status during his stay in my home and will be visited at regular intervals by a member of the Social Service Staff from the hospital.

I agree to notify the patient's physician or the social worker at the hospital, name and telephone number listed above, at once if there is any change for the worse in the patient's condition, either physical or mental, or if the patient absent himself from my home for any period of time without my knowledge or consent.

I further agree to notify a social worker or physician at the hospital, if my address is changed or if any other person becomes a member of my household. I have been informed that I have the right to request the patient's return to the hospital at any time, if he does not make a reasonable adjustment.

11. SIGNATURE OF APPLICANT	12. ADDRESS	13. DATE