ASSISTED LIVING STATUS STATEMENT

_____has been a patient receiving care
(Name Claimant)

_____ At _____
(Level of Care) **(Facility Name)**

since_____because of_____
(Date) **(Diagnosis of Major Conditions)**

and need for such care is considered to be permanent.

Is the claimant considered mentally capable of handling their own affairs? YES or NO

_____
Signature of Facility Physician or Private Practitioner

_____
Signature of Administrator

_____
Name of Assisted Living Facility

_____
Address Line 1 of Assisted Living Facility

_____
City, State Zip

I hereby certify that the above is true to the best of my knowledge and belief.

_____
Signature of Claimant