AFFIDAVIT OF ATTENDANT CARE SERVICES PERFORMED

Name of Insured: _____
Claim #: _____ Date of Incident: _____
Service Provider's Name: _____

Describe specifically what attendant care services were provided:

A. Assistance with Hygiene	G. Eating	M. Safety Supervision
B. Grooming	H. Meal Preparation	N. _____
C. Bathing	I. Medication Management	O. _____
D. Toileting	J. Care of Health Equipment	P. _____
E. Transferring/Positioning	K. Management of Finances	Q. _____
F. Physical Therapy Oversight	L. Wound Care	

On the following calendar, please indicate: (a) the services by letter; (b) the dates on which those services were performed; and (c) the number of hours required for performance of those services for each date.

Month: _____

1 Hours:	2 Hours:	3 Hours:	4 Hours:	5 Hours:	6 Hours:	7 Hours:
8 Hours:	9 Hours:	10 Hours:	11 Hours:	12 Hours:	13 Hours:	14 Hours:
15 Hours:	16 Hours:	17 Hours:	18 Hours:	19 Hours:	20 Hours:	21 Hours:
22 Hours:	23 Hours:	24 Hours:	25 Hours:	26 Hours:	27 Hours:	28 Hours:
29 Hours:	30 Hours:	31 Hours:				

Total hours: _____ Charge per hour: _____ Total Due: _____
Have you provided services prior to the accident: _____
I expect to be paid for all services provided.
I declare the above information to be true and accurate and above services were performed as indicated.

_____
(signature of party performing services) (date)

_____
(signature of insured) (date)