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

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)