Form 4 -- Claimant's Certification

(This report is used to verify actual out-of-pocket and recurring medical expenses)

Name of Claimant (Veteran or Surviving Spouse)	Name of Veteran		VA Claim Number or Veteran's SSN	
Claimant's Address	City	State	Zip	Contact Phone

STATEMENT OF CHARGES

Recurring monthly charges for assisted living, home care, adult day care, etc.
(total of veteran and spouse if applicable) _____

Plus monthly health insurance premiums
(total of veteran and spouse if applicable) _____

Less all reimbursement for these charges - _____

Monthly out-of-pocket after reimbursement _____

CLAIMANT CERTIFICATION

I certify the monthly medical expense listed above as "Monthly out-of-pocket after reimbursement" is being paid from personal household funds. These expenses are being paid out-of-pocket without reimbursement from any source. I request this amount be used as a prospective 12-month, annualized deduction for the purpose of calculating my household IVAP

_____
Signature of Witness

_____
Signature of Claimant

_____
Signature of Witness

Witnesses are only required if the claimant signs with a mark. Two different people must witness the mark signature.

_____
Date