ATTENDANT CARE
DISABILITY CERTIFICATE

I, _____, have examined and/or treated
(Name of Doctor)

_____, for the following injuries/diagnosis codes
(Name of Patient)

_____

_____

_____

sustained in a motor vehicle accident on _____. It is my opinion that as a
(Date of accident)

result of the injuries received in this accident, the aforementioned patient needs help with all or some of the following:

> **"ACTIVITIES OF DAILY LIVING"** such as Bathing, Dressing, Ambulation, Styling/combing of hair, Help using the toilet, Carrying or lifting things for the patient, Assisting with medication, and Supervision for safety reasons.

It is my opinion that the patient (is/was) disabled and in need of ATTENDANT CARE as described above from _____ to _____. The patient needs help _____ days each week at _____ hours per day.

_____
Doctor's signature

_____
Address

DATED: _____

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)