Affidavit of Attendant Care Claim

CLAIM NUMBER: LP-333670
INSURED NAME: DR AZHAR&GEORGES ESHO
INJURED PERSON NAME: GEORGES ESHO
GUARDIAN NAME: -No guardian appointed ☐
CONSERVATOR NAME: -No conservator appointed: ☐
CARE PROVIDER(S) NAME, ADDRESS & PHONE NUMBER:

RELATIONSHIP TO INJURED PERSON:
ADDRESS WHERE SERVICES WERE PROVIDED:
CARE PROVIDER(S) SOCIAL SECURITY NUMBER:
HAVE YOU BEEN PAID FOR YOUR SERVICES? ☐ YES ☐ NO
HAVE YOU PROVIDED SIMILAR SERVICES FOR THE INJURED PERSON PRIOR TO DATE OF THIS ACCIDENT?
☐ NO ☐ YES If yes, please explain:

ATTENDANT CARE SERVICES PROVIDED (check all that apply):

A: Supervision ☐
B: Bathing/Grooming /Hygiene Care ☐
C: Administer Medications ☐
D: Wound Care ☐
E: Feeding ☐
F: Bed/Wheelchair Transfers ☐
G: Bowel Program ☐
H: Catheter Care ☐
I: Other: ☐ please describe: ____________ ____________
____

MONTH: YEAR: 20

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:
Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:
Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:
Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:
Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:	Start Time: End Time: Total Hours: Services:

NOTICE: Insurance fraud is a felony. Any person convicted of fraud may be subject to up to 4 years imprisonment or a fine of up to $50,000 or both. Persons found to have conspired to commit insurance fraud may be subject to imprisonment for up to 10 years or a fine of $50,000 or both.

By signing below, you are confirming the above to be a true statement of the attendant care services you are claiming.

INJURED PARTY OR REPRESENTATIVE: ______________________ DATE: __________

CARE PROVIDER'S NAME: ______________________________

CARE PROVIDER'S SIGNATURE: ______________________________ DATE: __________