VERMONT
Department of Vermont Health Access

DVHA-14

Homestead Exemption Documentation

Services given by family delayed nursing home placement by at least 6 months

This form must be completed by <u>each</u> sibling or lineal heir claiming exemption.
Please complete both sides.

Part I –*Please check paragraphs as appropriate and complete the affidavit. (Lineal heirs typically include one or more children or siblings of the deceased, or their spouses.)*

A.____ I provided services that delayed or avoided the placement of the decedent, _____, in a nursing home by at least six months. The care or service was provided no fewer than three times weekly and without compensation. If services were provided less frequently, they constituted an equivalent expenditure of time.

and/or

B.____ I provided financial assistance for services, which delayed or avoided the decedent's placement in a nursing home by at least six months. The services were provided no fewer than three times weekly. If services were provided less frequently, they constituted an equivalent expenditure of money.

C. Chronological list of services that you provided or care that you purchased. *(Please use the back of this form or attach a separate page, if more space is needed.)*

Date of service	***Type of service provided or purchased***	***Provider***	***Time spent or cost paid***

Affidavit

I, _____, declare that the above statement is true and that my spouse or I provided the care listed on this form. I understand the information I provide will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify this information. I understand that if any information is not true, I will be subject to prosecution for fraud and/or another criminal offense for knowingly giving false, incorrect, incomplete, or misleading information.

Signature of heir: _____

Relationship to decedent: _____

Subscribed and sworn to before me this _____ day of _____, 20 ___ .

_____
Notary Public

My commission expires: _____

Part II – ***To be completed by the decedent's physician or other qualified health care provider***
(Providers with questions may contact OVHA's Coordination of Benefits Unit at 879-5900 for more information.)

The decedent was under my care at the time that the care, described above, was rendered. I believe that the care, described above, was medically necessary, consistent with the level of care provided by level III residential care homes, and delayed nursing home placement by at least 6 months. Care provided in a level III residential care home includes assistance with meals, dressing, movement, bathing, grooming, or other personal needs, or general supervision of physical or mental well-being, including nursing overview and medication management.

_____ _____
_____

Date Health Care Provider (signature) Health Care Provider (printed name)

(If you have questions, please contact Jennifer Whalen @ DVHA's Member Provider Services Unit at 802-241-9343 or jennifer.whalen@vermont.gov)

Please mail this form to:

State of Vermont
Department of Vermont Health Access
ATTN: Member Provider Services Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-4020