ATTENDANT CARE FORM

Claimant _____ Claim No.: _____
Provider Name: _____ Provider Phone No.: _____
Provider Address: _____
Rate of Pay: $ _____ per hr $_____ per day $_____ per week $_____ per month
Provider Signature: _____ Provider Social Security No.: _____

Description of specific service performed and amount of time required for each day:

Date	Amount of time	What was specifically done

Please note, if any of the boxes below are not acknowledged, the document will be considered incomplete and will be returned for further completion. The claim cannot be considered until all acknowledgments are checked.

☐ I have reviewed this document and attest that the information contained therein is true and accurate.

☐ I acknowledge I have read the following fraud warning:

A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan Property & Casualty Guaranty Association ("MPCGA") for payment or any other benefit knowing and with an intent to injure, defraud, or deceive the MPCGA that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under the insurance code that is subject to the penalties imposed by law. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment or benefits by the MPCGA.

By signing below I certify the above services were provided

Guardian/Claimant Signature: _____ Date: _____