IMPORTANT! This report must be sent in by the 5th of every month. Late reports will result in payment being pushed to the next month's payment cycle.

Monthly Client Care Hours Report

AGENCY NAME		
MONTH / YR. OF CARE		20____

CLIENT FIRST & LAST NAME	APPROVED MONTHLY HOURS OF CARE

I CERTIFY THAT THE ABOVE APPROVED HOURS OF CARE WERE PROVIDED TO EACH CLIENT OR WE WILL MAKE UP ANY MISSED HOURS OF CARE WITHIN THE NEXT 28 DAYS.

HOME CARE AGENCY CASE MANAGER NAME: _____

DATE: _____ **PHONE NUMBER:** _____

Email this form to: billing@careplanninginstitute.org or Fax to: 800-466-6001. No cover letter required.

IMPORTANT: YOU CAN ONLY BE PAID FOR THE APPROVED HOURS OF CARE EACH MONTH. ANY HOURS OF CARE PROVIDED ABOVE THE APPROVED HOURS OF CARE WILL NOT BE PAID BY THE VA BENEFIT.

