

# CERTIFICATION

REGARDING

## RESIDENTS' PERSONAL NEEDS FUNDS

I, \_\_\_\_\_,

(Please Print) First Name, Last Name

Administrator of \_\_\_\_\_ Facility Lic # \_\_\_\_\_

(Please Print) Name of Facility

Hereby certify that Resident Personal Needs funds are being handled at this facility in accordance with the "Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities and ICF-DD Facilities, and Assisted Living Residences"

\_\_\_\_\_  
Signature of Administrator

\_\_\_\_\_  
Date

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This Certification is to be submitted, along with the CHECKLIST OF INFORMATION FOR DESK AUDIT, to:

**THE STATE OF RHODE ISLAND  
RATE SETTING UNIT  
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES  
3 WEST ROAD, CRANSTON, RI 02920**