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

This Certification is to be submitted, along with the DOCUMENTS SUBMISSION CHECKLIST FOR DESK AUDIT, to:

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