W CY 2016 BM

CERTIFICATION

REGARDING

RESIDENTS' PERSONAL NEEDS FUNDS

I, ____,
(Please Print) First Name, Last Name

Administrator of ____
(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-MR Facilities [Effective October 1, 1990, Modified May 2010]"

_____________________________________ ___________________
Signature of Administrator Date

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

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