Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: _____

Resident's Name
(*Please Print*): _____

Medicaid No. _____ Date of Admission: _____

1. I, _____ (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: _____ Date: _____ Title: _____

2. I, _____ (*Resident Signature)*, direct that my monthly personal needs allowance be given to _____. (*Name/Relationship)*

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3. I, _____ (*Resident Signature),* direct that my monthly personal needs allowance be held by the facility and be administered in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed by: _____ Date: _____ Title: _____
Witnessed by: _____ Date: _____ Title: _____

3a. ADDENDUM: (Amount left on hand cannot be greater than $75.00) Periodically, monies are left by the responsible party for incidentals, hairdresser, etc. to be administered by the facility in accordance with the *Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds* regulations.

Witnessed: _____ Date: _____ Title: _____

RESIDENT UNABLE TO SIGN: _____ Date: _____ Reason: _____

Witness signature_____ Date_____

Witness signature_____ Date_____

Guardian Signature_____

Power of Attorney _____ (Attach copy)

Exhibit "B"

NOTARIZED STATEMENT RELATED TO AMOUNT OF PERSONAL NEEDS MONEY AVAILABLE UPON A RESIDENT'S DEATH

MEDICAID_____ NON-MEDICAID_____

RESIDENT'S NAME:_____

DATE OF DEATH:_____ SOCIAL SECURITY#_____

AMOUNT OF PERSONAL NEEDS FUNDS AT TIME OF DEATH: $_____

AMOUNT OF UNUSED APPLIED INCOME AT THE TIME OF DEATH: $_____

DISBURSEMENTS (ATTACH COPIES OF RECEIPTS) $_____

TO WHOM FUNDS DISPERSED:

NAME: _____

ADDRESS: _____

BALANCE TO ESTATE RECOVERY:$_____

NEXT OF KIN'S NAME: _____(Must be filled in or, if not known, "NA" must be noted).

ADDRESS: _____

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

FACILITY NAME AND ADDRESS: _____

_____

Signature of Facility Representative_____

NOTARY PUBLIC_____

Date _____

Please send this notarized statement to:
Executive Office of Health and Human Services
TPL Unit – Estate Recovery
74 West Road
Cranston RI 02920

Exhibit "C"

ESTATE RECOVERY FUNERAL HOME ATTESTATION

It is the responsibility of the funeral home requesting personal needs funds from a nursing home to submit this form along with the updated funeral bill and prepaid burial contract. If this form is not completely filled out and the requested documentation is not presented with this form, the personal needs funds will not be released to the funeral home. The Rhode Island Executive Office of Health and Human Services Estate Recovery Unit will then review the documents and instruct the nursing home of the total amount of funds that can be distributed to the funeral home for payment towards the outstanding funeral bill. Please fax to 401-462-3350 ATTN: Estate Recovery. Any questions should be directed to Estate Recovery at 401-462-1190.

Deceased Name_____

SS#_____

Date of Death _____

Funeral Home Contact Name and Number_____

Funeral Home Name and Address_____

Nursing home name & telephone number_____

DISCLOSURE OF CHARGES AND CREDITS

1. Total Burial Charges (provide invoice copy) $_____

2. Prepaid Burial Contract (provide copy) $_____

3. Insurance Payment $_____

4. Burial Set Aside $_____

5. Miscellaneous Credits $_____

6. Final Invoice Charges (attach invoice copy) $_____

I, _____(print name) certify under penalty of perjury under the laws of the State of Rhode Island that the information provided herein is true and correct. I further declare, if any future credits are applied to this account which would generate a credit and there is no surviving spouse the refund will be sent to EOHHS at the above address.

Signature:_____

Title: _____Date:_____