Clarification on Personal Needs Allowance (PNA) Authorization Form/Exhibit A

The facility must have a PNA Authorization Form/Exhibit A on file for each resident that accurately identifies the party responsible for the PNA account.

The below color-coded categories correspond to the applicable fields on the form (on the next page) depending on who is responsible for the resident's PNA.

**Note: Signatures by resident or Power of Attorney must be witnessed on the form.*

- Green (#1) = Indicates resident is responsible for their own PNA
  - Green (#1) + Magenta (#3A)= Resident manages PNA and is opting to have an optional personal needs account with the facility.
- Blue (#2)= Indicates third party responsibility PNA
  - Blue(#2) + Magenta(#3A) = Third Party manages PNA and resident opts for an optional personal needs account with the facility.
- Orange = Facility is responsible for and holds the resident's PNA
- Yellow = To be completed if resident is unable to sign the form. Two witnesses, POA, or legal guardian signature required.

Exhibit "A"

PERSONAL NEEDS FUND AUTHORIZATION DOCUMENT

Date: 5/1/24

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

Medicaid No. ____________ Date of Admission: ____________

1. I, Resident Signs if Managing Own PNA (*Resident Signature*), direct that my monthly personal needs be given to me.

Witnessed by: Witness Date: ____________ Title: ____________

Resident Signs if POA/family manages PNA
2. I, ______________________ (*Resident Signature*), direct that my monthly personal needs allowance be given to Person who is managing PNA ____________.
(*Name/Relationship*)

Witnessed by: Witness Date: ____________ Title: ____________
Witnessed by: Witness Date: ____________ Title: ____________

3. I, Resident Signs if facility manages PNA (*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: witness Date: ____________ Title: ____________
Witnessed by: witness 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: signs if optional PNA acct Date: ____________ Title: ____________

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

Witness signature This Portion filled out if resident can't sign Date____________

Witness signature______________________ Date____________

Guardian Signature______________________

Power of Attorney ______________________ (Attach copy)