**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 Rd
Cranston RI 02920