



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
Estate Recovery
3 West Rd Virks Bldg 3rd fl
Cranston RI 02920