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 $50.00) 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:________________________________________