

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
HAZARD BUILDING
74 WEST ROAD
CRANSTON, RI 02920

UNIFORM ACCOUNTABILITY PROCEDURES
FOR TITLE XIX RESIDENT PERSONAL NEEDS FUNDS
IN COMMUNITY NURSING FACILITIES AND ICF-MR FACILITIES
EFFECTIVE OCTOBER 1, 1990

(Modified May 2010)

INTRODUCTION

Use of and accountability for funds of residents residing in community medical care, ICF-MR facilities and Nursing Care Facilities is an essential requirement for the protection of the residents' rights. In order to ensure proper program and fiscal accountability for these funds and to meet federal law and regulations, the following procedures must be in effect in all facilities for who the Department of Human Services is responsible for payment through the Title XIX Medical Assistance Program.

- I. The State of Rhode Island, through the Department of Health, will review, certify and re-certify that the facility has adopted the written policies and procedures included herein pertaining to the resident accounts, and verifies that such policies and procedures are being followed.
- II. The Department of Human Services will interview residents and review resident records to determine whether they:
 - A. Have access to their personal funds held by the facility.
 - B. Know the current status of their accounts.
 - C. Receive in writing, and have explained if necessary, at least quarterly accountings of transactions made on their behalf.
 - D. Can ensure that their resources, including personal needs funds, are within the limits for continued eligibility.
 - E. Review resident's records to verify a quarterly accounting of deposits, withdrawals and balances has been completed.

In cases in which a member of the resident's family or a guardian assumes responsibility for personal needs funds due to an inability of the resident to manage such funds, the above points will be addressed to such persons rather than the resident, as appropriate.

- III. The State of Rhode Island or its designee will audit Residents Personal Needs Accounts held by the facility to ensure accountability within the procedures and requirements specified within. This audit will be conducted by the Nursing Facility Rate Setting Unit or its designee.
- IV. Resident personal needs allowances are for the sole use of the resident for such items as, but not limited to, haircuts, beauty parlor, tobacco, clothing, preference brand items, etc. Personal Needs Allowances may be used for the payment of Reserve Bed Days but may not be used for the payment of Applied Income Balances or items covered as routine services or medicine chest supplies as identified in the Principles of Reimbursement. Personal Needs Allowances may not be used for items which the facility is reimbursed through the Medicaid Program

- V. Each facility shall obtain, upon admission or adoption of these regulations from the resident, guardian, next of kin or person responsible for the resident, a signed and witnessed document indicating the wishes of the resident as to the manner in which personal funds are to be handled. For residents who cannot sign the Authorization Document, it is required that two (2) appropriate employees sign the document and attach a statement to that effect. A recommended copy, to be utilized after February 1, 2007, is attached as Exhibit 'A'. An Authorization Document must be on file for all residents who have funds in the Personal Needs Fund, including non-Medicaid residents.

Exhibit 'A' clearly provides the following choices:

1. Resident as responsible party.
 2. Guardian, next of kin, or other individual as responsible party.
 3. Facility as responsible party.
 - 3a. Addendum: In addition to section V, items 1 and 2 - Periodically monies are left by the responsible party above for incidentals to be administered by the facility in accordance with the Uniform Accountability Procedures for Title XIX Patient Personal Needs Funds in Nursing Facilities. The amount on hand cannot exceed one month's personal needs allowance. If the funds exceed this amount, a new Authorization Document must be established for the resident.
- VI. If the signed statement indicates the resident's choice is for the facility to handle the personal needs funds, the following requirements must be met:
1. The responsibility for handling the Resident Personal Needs Funds should be limited to specific individuals who are accountable for such funds. Each facility must maintain a Surety Bond for the Personal Needs Funds in accordance with CFR 42 Section 483.10 (c) (7). The obligee of the Surety Bond must be the State of Rhode Island. The amount of the Surety Bond must be greater than all personal funds of the residents at the facility.
 2. Each resident must be given a written quarterly accounting of his/her deposits, withdrawals and balances at least quarterly, i.e. March 31, June 30, September 30, and December 31. The facility must keep a copy of such itemized accounting with the resident's records.
 3. Resident personal needs funds must not be commingled with general funds of the facility or with any other funds.
 4. When the individual's balance exceeds \$ 50.00, the excess shall be deposited into an interest bearing checking account in the name of the facility followed by the words "Resident Personal Needs Funds, an interest bearing savings account in the name of the facility followed by the words "Resident Personal Needs" or into a savings account in the name of the resident and his/her designee. The resident savings accounts must remain in the custody of the facility. Interest

earned in the checking or savings account must be pro-rated to each resident having a balance in the account.

5. Individual resident ledger cards showing name, deposit, withdrawals and balance for checking, savings and petty cash accounts must be established and maintained by the facility. It is noted that if a facility utilizes and maintains an Imprest Petty Cash fund , petty cash does not have to be listed on the ledger card.
 6. A separate petty cash fund entitled “ Petty Cash – Residents Personal Needs” showing original balance, withdrawals supported by signed receipts, deposits in the petty cash fund from the checking account entitled “ Resident Personal Needs”, and balance on hand. Resident Personal Needs Funds petty cash must not be co-mingled with the operating accounts petty cash fund, or any other petty cash funds and the operating accounts petty cash fund must not be utilized for Resident Personal Needs Funds.
 7. The amount of Petty Cash – Resident Personal Needs Account must not exceed the amount of \$50.00 (or any subsequent increase to the Personal Needs Allowance) for each resident choosing the facility to handle their funds.
 8. Each withdrawal from the Resident Personal Needs Accounts (petty cash, checking or savings) shall be documented by a two-part signed and witnessed receipt showing date in full, name of resident, amount of withdrawal and purpose. The original is to be kept by the facility and the copy given to the resident. For residents who cannot sign, two (2) signatures of appropriate employees would be required. For withdrawals for such items such as hairdresser, bus trips, etc., a master list would be an acceptable receipt if signed by the vendor and the representative from the facility who pays the invoice.
 9. The resident personal needs ledgers, when totaled, will agree to the balance of the “Resident Personal Needs’ checking account, individual savings account if applicable, plus the amount represented in the Resident Personal Needs – Petty Cash Account. Residents are not allowed to carry negative balances in their accounts. This reconciliation must be done on a monthly basis and retained for verification at time of audit.
 10. The nursing facility must notify the resident in writing when his/her balance reaches \$ 200.00 less than the resource eligibility guideline, that Medicaid eligibility is jeopardized if the account exceeds the guideline.
- VII. If the statement indicates the resident, guardian, next of kin, or other person responsible for the resident is to handle the personal needs funds, the facility shall have on file a receipt signed by the resident or other responsible person to ensure that each month’s personal needs check or funds were actually received by the resident or other responsible person. Such receipt must show the amount of the check or the amount of money received by the resident or other

responsible person. This requirement will apply only in those instances in which checks for personal income including SSI are mailed directly to the facility. A bank processed cancelled check is acceptable as evidence of receipt.

VIII. Disposition of Resident Personal Needs funds upon 1) Discharge, 2) Transfer to another Long Term Care Facility, or 3) Death:

1. Upon discharge to community living, the resident shall be given his/her Savings passbook and the funds so accumulated to his/her ledger from the resident Personal Needs Checking Account, and shall sign a receipt for such savings passbook and balance of personal needs funds.
2. Upon transfer to another long-term care facility, the resident's savings passbook and balance of resident's personal needs funds shall be transmitted to the administrator of the new facility within ten days of such transfer. The administrator of the new facility shall furnish a signed receipt for said savings passbook and balance of personal needs fund to the administrator of facility from which said resident was transferred.
Upon the death of a Medicaid resident, a facility shall, within ten days, transmit a notarized statement (see Exhibit 'B') indicating the amount of personal needs money on hand after funeral expenses. Funeral expenses are designated to be the first paid. Copies of receipts, obtained either from the funeral home or the relative responsible for the funeral should be included.

If the deceased recipient is survived by a spouse, a child under twenty-one, or a child that is blind or permanently disabled in accordance with title XVI of the Social Security Act, the balance of the personal needs funds on hand, after payment of funeral expenses, may be transmitted to those individuals.

If there is a balance in the Medicaid resident's personal needs account, after payment of the above noted disbursements, a check payable to the Department of Human Services in that amount shall be sent along with the copy of the notarized statement and receipts to:

Department of Human Services
Attention: TPL Unit – Estate Recovery
Hazard Building, 74 West Road
Cranston, RI 02920

Even if there is a \$0.00 balance, the form must be filled out and sent in.

Resident Personal Needs Funds cannot be utilized for the payment of Applied Income balances.

AUTHORIZATION DOCUMENT

EXHIBIT 'A'

(Utilize this form after 4/1/07)

Date: _____

Resident's Name (Please print): _____

Medicaid No. _____ Date of Admission : _____

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

Witness' Signature Date Name (PRINT)
Title : _____

2. I, _____, direct that my monthly personal needs allowance be given to
(Resident's Signature)

(Relationship Signature Name (PRINT)

Witness' Signature Date Name (PRINT)
Title : _____

Witness' Signature Date Name (PRINT)
Title : _____

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

Witness' Signature Date Name (PRINT)
Title : _____

Witness' Signature Date Name (PRINT)
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.

Witnessed : _____ Date: _____
Title : _____

IF RESIDENT IS UNABLE TO SIGN: (check mark) _____ Date _____

Reason _____

Witness' Signature Date Name (PRINT)

Witness' Signature Date Name (PRINT)

Guardian's Signature Name (PRINT) (check) _____
Power of Attorney (Attach copy)

EXHIBIT 'B'

MEDICAID_____

NON-MEDICAID_____

RESIDENT'S NAME : _____

DATE OF DECEASE : _____ SOCIAL SECURITY # _____

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

DISBURSEMENTS (ATTACH COPIES OF RECEIPTS) \$ _____

TO WHOM- NAME: _____

ADDRESS: _____

BALANCE:\$ _____

NEXT OF KIN :

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

FACILITY NAME AND ADDRESS: _____

Notary Public

Signature of Facility Representative

Date