Department for Aging and Rehabilitative Services

# AUXILIARY GRANT CERTIFICATION

| REPORTING PERIOD | July 1, 2015 to June 30, 2016 | | |
|---|---|---|---|
| ***1. Facility Information*** | | | |
| **Facility Name** | | | |
| **Owner/Licensee Name** | | | |
| **Facility Address** | | | |
| **City** | | **State** | **Zip** |
| **Facility Phone Number** | | **Facility Fax Number** | |
| **City or County** | | | |
| **Facility Mailing Address (If different)** | | | |
| **City** | | **State** | **Zip** |

| | |
|---|---|
| ***2. Resident / Bed Information*** | |
| **2.a. Total Licensed Beds** | |
| **2.b. Average monthly resident census (all residents)** | see instructions |
| **2.c. Average monthly AG residents census** | see instructions |
| ***3.* DO YOU RECEIVE THIRD PARTY PAYMENTS FOR YOUR AG RESIDENTS? (see definition in instructions)** | ☐ Yes ☐ No |

| | | |
|---|---|---|
| ***4. Personal Needs Allowance (PNA) Accounting*** | | |
| **A. Complete section below if facility manages PNA for all or some of the AG residents** | | |
| **Number of AG residents for which the Facility maintains a personal needs allowance account** | **# at Beginning of Reporting Period** | **# at End of Reporting Period** |
| | | |
| ***Please answer yes or no to the following questions:*** | | |
| **If the ALF manages residents' personal funds, written permission to do so has been granted by the residents or by their personal representative. 22VAC40-72-150, 63.2-1808** | | ☐ Yes ☐ No |
| **If the ALF holds personal funds for safekeeping on behalf of the resident, a written accounting showing funds received and disbursed, and a current balance, is maintained. 22VAC40-72-150** | | ☐ Yes ☐ No |
| **PNA funds are kept separate and apart from other ALF funds. 22VAC30-80-45** | | ☐ Yes ☐ No |
| **PNA funds have been maintained in accordance with 22VAC30-80-40** | | ☐ Yes ☐ No |

**B. Answer the following question if the ALF does not maintain PNA for any residents:**

**Does the facility have a written policy prohibiting the ALF from managing personal funds for any AG resident?**
☐ Yes ☐ No

**C. Please complete the Auxiliary Grant Recipients Reconciliation Form**

***5. Certification***

**I certify that the information submitted with this report is true and complete. If the ALF manages the personal fund of the residents, I certify that procedures are in place for the proper handling of and accounting for residents' Auxiliary Grant payments and personal needs allowances in accordance with the Code of Virginia §51.5-160 and with Auxiliary Grant regulations 22VAC 30-80 and Licensing regulations 22VAC40-72-140, 22 VAC 40-72-150 and 22VAC40-72-550. I certify that I have reviewed the provider agreement and will continue to follow the agreement for the next fiscal year.**

| | |
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| | |
| **Owner/Licensee Signature:** | **Date** |
| **Owner's/Licensee's email address**: | |
| **Print Name of Person Completing Form:** | **Title:** |

# AUXILIARY GRANT CERTIFICATION

## AUXILIARY GRANT RECIPIENTS RECONCILIATION FORM
## Reporting Period: July 1, 2015 to June 30, 2016

**Name of Facility:**

| | Name of resident | Birth date | Admission Date | Discharge Date | Reason for Discharge |
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## AUXILIARY GRANT RECIPIENTS RECONCILIATION FORM
## Reporting Period: July 1, 2015 to June 30, 2016

**Name of Facility:**

| | Name of resident | Birth date | Admission Date | Discharge Date | Reason for Discharge |
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(Please use additional copies if needed)

**Department for Aging and Rehabilitative Services**

# AUXILIARY GRANT CERTIFICATION

**Instructions for completing Auxiliary Grant Certification**

1. Enter Facility Information.

2. Resident/Bed Information

   2.a. Enter total number of beds for which facility is licensed.

   2.b. Determine the number of ALF residents for each month of the reporting period(i.e. Jan, Feb, etc.) Add the total for each month to determine the total number of residents for the reporting period. Divide this number by 12. This number is the average monthly resident census.

   2.c. Determine the number of residents that received AG for each month of the reporting period. Add the total for each month to determine the total number of residents that received AG for the reporting period. Divide this number by 12. This number is the average monthly AG resident census.

3. Third party payments are additional payments voluntarily given to ALF provider to cover goods and services for a resident that are not services and goods that are already provided under the Auxiliary Grant payment.

4. Answer section A or B. Answer questions in section A if the ALF maintains PNA accounts for AG residents. **Please note that if you are holding residents' funds it means you are managing the funds.** Answer the question in section B if the ALF does not maintain PNA accounts for <u>any</u> AG residents. **Complete the pages entitled Auxiliary Grant Recipient Reconciliation Form**. See Reconciliation Form instructions below.

5. Read the certification, print, sign name and date form. Provide title and telephone number. You can mail it the address below, fax it or you can save document as a .doc file and email it to Venus.Bryant@dars.virginia.gov

**<u>Auxiliary Grant Recipients Reconciliation Form Instructions</u>:**

List all AG residents on Reconciliation Form. **Include all AG residents who lived in the facility during the reporting period,** even if they were admitted to the facility prior to the reporting period. If the resident is still living at the facility on the last day of the reporting period, enter NA in the "discharge date" box and if they were discharged indicate the "reason for discharge" in the box.

**Mail Certification form to**: Department of Aging and Rehabilitative Services
Adult Protective Services Division
8004 Franklin Farms Drive
Richmond, Virginia 23229
FAX 804-662-9335

**Must be submitted by October 1, 2016**