

Department for Aging and Rehabilitative Services

AUXILIARY GRANT CERTIFICATION

REPORTING PERIOD		July 1, [YEAR] to June 30, [YEAR]	
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)		<input type="checkbox"/> Yes <input type="checkbox"/> No Type of payment: _____	
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	# of clients at Beginning of Reporting Period	# clients at End of Reporting Period	
<i>Please answer <u>yes</u> or <u>no</u> to the following questions:</i>			
If the ALF manages residents' personal funds, written permission to do so has been granted by the residents or by their personal representative. 22VAC40-73-400 , 63.2-1808		<input type="checkbox"/> Yes <input type="checkbox"/> 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. 22VAC40-73-400		<input type="checkbox"/> Yes <input type="checkbox"/> No	
PNA funds are kept separate and apart from other ALF funds. 22VAC30-80-45		<input type="checkbox"/> Yes <input type="checkbox"/> No	
PNA funds have been maintained in accordance with 22VAC30-80-40		<input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Answer the following question if the ALF does <u>not</u> maintain PNA for any residents:			
Does the facility have a written policy prohibiting the ALF from managing personal funds for any AG resident? <input type="checkbox"/> Yes <input type="checkbox"/> 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 22VAC40-73-400 , 22VAC40-73-90 and 22VAC40-73-550 . I certify that I have reviewed the provider agreement and will continue to follow the agreement for the next fiscal year.			
Owner/Licensee Signature:		Date	
Owner's/Licensee's email address:			
Print Name of Person Completing Form:			Title:

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AUXILIARY GRANT RECIPIENTS RECONCILIATION FORM
Reporting Period: July 1, [YEAR] to June 30, [YEAR]

Name of Facility:

	Name of resident	Birth date	Admission Date	Discharge Date	Reason for Discharge
1					
2					
3					
4					
5					
6					
7					
8					
9					
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Department for Aging and Rehabilitative Services

AUXILIARY GRANT CERTIFICATION

AUXILIARY GRANT RECIPIENTS RECONCILIATION FORM
Reporting Period: July 1, [YEAR] to June 30, [YEAR]

Name of Facility:

	Name of resident	Birth date	Admission Date	Discharge Date	Reason for Discharge
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
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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. This also includes any DAPS funds from CSB.
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 any 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.
Effective August 2018, you are to mail the form in only. It needs to be postmarked by October 1, [YEAR].

Auxiliary Grant Recipients Reconciliation Form Instructions:

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 For Aging and Rehabilitative Services
Division for Community Living
5620 Cox Road
Glen Allen, Virginia 23060