Department for Aging and Rehabilitative Services

AUXILIARY GRANT CERTIFICATION SH

REPORTING PERIOD	July 1, [YEAR] to June 30, [YEAR]		
1. Supportive Housing Information			
Supportive Housing Provider Name			
Address			
City		**State**	**Zip**
Phone Number		**Fax Number**	
City or County			

2. Resident / Bed Information	
2. a. Supportive Housing clients licensed to serve	
2. b. Average monthly AG residents in SH	see instructions
3. **DO YOU RECEIVE THIRD PARTY PAYMENTS FOR YOUR AG RESIDENTS? (see definition in instructions)**	☐ Yes ☐ No

4. Compliance Questions	
Please answer yes or no to the following questions:	
Basic services in a supportive housing setting has been maintained in accordance with 22VAC30-80-35	☐ Yes ☐ No
Accepts the AGSH Provider rate as payment in full for services delivered under the DBHDS agreement.	☐ Yes ☐ No
Attest that services are provided by providers licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with DBHDS and whose license are in good standing.	☐ Yes ☐ No
Personal needs allowance is being used by the individual for their personal needs and not commingled with funds of the provider.	☐ Yes ☐ No
As a condition of participating in the AG program, the SH provider maintains the provisions outlined in the agreement with Department of Behavioral Health and Developmental Services.	☐ Yes ☐ No
C. Please complete the Auxiliary Grant Recipients Reconciliation Form (attached)	

5. Certification	
I certify that the information submitted with this report is true and complete. I certify that the supportive housing provider adheres to operating guidance for supportive housing according to AG regulations 22VAC30-80 and is in compliance with §37.2-421.1 and have reviewed the DBHDS provider agreement and will continue to follow the agreement for the next fiscal year.	
Supportive Housing Provider Signature:	**Date**
email address:	
Print Name of Person Completing Form:	**Title:**

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

	Name of resident	Birth date	Admission Date	Discharge Date	Reason for Discharge
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
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18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					

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					
41					
42					
43					
44					
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(Please use additional copies if needed)

Department for Aging and Rehabilitative Services

AUXILIARY GRANT CERTIFICATION SH

Instructions for completing Auxiliary Grant Certification

1. Enter Provider Information.

2. Census Information

   2.a. Enter total number of client's license to served according to the DBHDS provider agreement.

   2.b. Determine the number of AG 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 individuals for the reporting period. Divide this number by 12 this number is the average monthly client census.

3. Third party payments are additional payments voluntarily given to SH provider to cover goods and services for a resident that are not services and goods that are already provided under the Auxiliary Grant payment. (i.e. deposits for rent, purchases for household supplies)

4. Answer the following compliance questions.

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

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

List all AG residents on Reconciliation Form. **Include all AG individuals who you served during the reporting period,** even if they were admitted to supportive housing prior to the reporting period. If the resident is still living in supportive housing 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

Must be submitted by October 1, [YEAR].