Statement of Members' Personal Needs Accounts

Commonwealth of Massachusetts • Executive Office of Health and Human Services • Office of Medicaid

Name of Facility	Provider Number
Address	Business Phone
City/Town State Zip	Business Fax

I hereby certify under penalty of perjury that the information in this report and any attachments is true and correct to the best of my knowledge and belief.

Prepared by (please print)	Signature	Date / /
Administrator (please print)	Signature	Date / /

Please check here if you **do not** maintain PNA accounts for MassHealth residents. ☐

THE FOLLOWING INFORMATION IS REQUIRED IN ADDITION TO A COMPLETED PNA-I.

Please submit the patient balances in one of the following formats. (Circle your choice.)

1. 3½" Disk
2. CD
3. Electronic Printout (Excel, Access)
4. Handwritten on the enclosed PNA-2 form

I. A listing of all MassHealth members whose PNA funds are managed by the facility

This must include:

- Member name (first and last)
- Social security number
- Account balance as of March 31, 2006
- Bank book number or aggregate trustee bank account number

2. A COPY of the aggregate trustee bank statement or individual member account statements as of March 3I, 2006

3. An account reconciliation. If individual accounts are held for members, an account reconciliation is not necessary.

COMPLETE THIS SECTION

Total number of **MassHealth** members listed
List should NOT include private patients.

___ ___ ___

Total PNA balance of **MassHealth** members
Total PNA balance should equal the reconciled bank balance.

$ ___ ___ ___ , ___ ___ ___ . ___ ___

Date of PNA Balance ____/____/____

Date of Bank Statement ____/____/____

Name of Bank(s) _____

_____

_____

Return to: Financial Compliance Unit • 529 Main Street, 3rd Floor • Charlestown, MA 02129