



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



**MassHealth
Long Term Care Facility Bulletin 87
May 2004**

TO: Nursing Facilities, Chronic Disease and Rehabilitation Inpatient Hospitals, and Psychiatric Inpatient Hospitals Participating in MassHealth

FROM: Beth Waldman, Medicaid Director *BW*

RE: Annual Accounting for Personal Needs Allowance Funds

Background

MassHealth's regulations at 130 CMR 456.615 require that long-term-care facilities make an accounting of the balances of the personal needs allowance (PNA) funds for each MassHealth member for whom the facility handles funds. This accounting is usually due to MassHealth by June 1 of each year.

**July 1 Deadline
for PNA-1
Submissions**

To comply with these regulations, long-term-care facilities must use the PNA-1. This form must be dated and signed by the facility administrator and sent to the following address by **July 1, 2004**.

Office of Medicaid
ATTN: Sarah Meacham
Office of Financial Compliance
600 Washington Street
Boston, MA 02111

On the PNA-1, state the PNA balance for each MassHealth member as of **March 31, 2004**. Attach to the form a copy of the bank statement(s) and reconciliation(s) of the aggregate trustee bank account(s) as of **March 31, 2004**, along with a copy of the surety bond held by the facility, and submit these documents to the above address.

Providers may use their own reconciliation form or may use the reconciliation form attached to this bulletin (PNA-2). This form is available on-line on the MassHealth Provider Services Web site at www.mahealthweb.com/publications_and_forms.htm, where it can be printed and mailed to the above address. **Please Note:** The reconciled bank balance must agree with the **Total PNA Balance** on the PNA-1 form.

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**July 1 Deadline
for PNA-1
Submissions**
(cont.)

Providers using Microsoft Excel or Access to maintain listings of patient balances may submit these on a 3½" floppy disk or CD. It is suggested that these disks be enclosed in a disk mailer envelope. Attach the disk or CD to the PNA-1 form and indicate the list as an attachment on the PNA-1. The PNA-1 form can be downloaded from the MassHealth Provider Services Web site at www.mahealthweb.com/publications_and_forms.htm.

If a facility does not handle PNA funds for any members, the facility must state this on the PNA-1. The form must then be dated and signed by the facility administrator, and sent to the address listed on the front of this bulletin.

If a facility does not submit the PNA-1 by July 1, 2004, or if the form is incomplete, the facility may be subject to administrative sanction.

Copies of the PNA-1 and PNA-2 are enclosed with this bulletin. These forms may be photocopied as needed.

Questions

If you have any questions about this bulletin, contact Sarah Meacham at 617-241-6115.

Statement of Members' Personal Needs Account

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

Name of Facility			Provider Number 09 _____
Address			Business Telephone _____ - _____ - _____
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 _____ / _____ / _____

<p>Total number of MassHealth members listed (list should not include private patients)</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div> <p>Total PNA balance of MassHealth members (the total PNA balance should equal the reconciled bank balance as stated on PNA-2)</p> <div style="border: 1px solid black; width: 300px; height: 25px; margin: 5px auto; display: flex; align-items: center;"> \$ _____ , _____ . _____ </div> <p>Amount of surety bond held by facility</p> <div style="border: 1px solid black; width: 300px; height: 25px; margin: 5px auto; display: flex; align-items: center;"> \$ _____ , _____ , _____ </div>	<p>Date of PNA Balance _____ / _____ / _____</p> <p>Date of Bank Statement _____ / _____ / _____</p> <p>Name of Bank(s) _____ _____</p> <p>Are the following items enclosed?</p> <ul style="list-style-type: none"> • Account reconciliation (PNA-2) <input type="checkbox"/> yes <input type="checkbox"/> no • Copy of the aggregate trustee bank statement or individual member account statements <input type="checkbox"/> yes <input type="checkbox"/> no • Copy of facility's surety bond <input type="checkbox"/> yes <input type="checkbox"/> no
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MassHealth Member's Name	Social Security Number	PNA Balance	Bank Book No. and/or Aggregate Trustee Bank Account No.
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
	_____ - _____ - _____	\$ _____ , _____ . _____	
Total this page		\$ _____ , _____ . _____	

Bank Reconciliation for Members' Personal Needs Accounts as of March 31, 2004

Balance per bank as of March 31, 2004

\$ _____, _____.

Add Deposits in Transit

Date	Amount
	\$
	\$
	\$

Total Deposits in Transit

\$ _____, _____.

Deduct Outstanding Checks

Check Number	Amount	Check Number	Amount
	\$		\$
	\$		\$
	\$		\$
	\$		\$

Total Outstanding Checks

\$ _____, _____.

Add/Deduct Other Reconciling Items

Amount

	\$
	\$
	\$
	\$
	\$
	\$

Please indicate any funds that are held in the listed bank account(s) other than those for **MassHealth** members. For example, if any money is held for private patients, please indicate this amount, as well as any cash on hand, interest, service charges, etc. that may affect the account balance. **The reconciled bank balance should equal the Total PNA Balance as stated on PNA-1.**

Total Other Reconciling Items

\$ _____, _____.

Ending Balance

\$ _____, _____.

The Reconciled Bank Balance should equal the Total PNA Balance as stated on **PNA-1**.

Return to: Office of Medicaid • Attn: Sarah Meacham • Office of Financial Compliance • 600 Washington Street • Boston, MA 02111