Attachment 3

Roster of Eligible Residents for the Enriched Housing Operating Assistance Subsidy

Report Year (YYYY)	**2020**	**State Fiscal Year 2020-21**
Report Month		
OC #		
Facility Name		
Facility Address		
City		
State		
Zip Code		
Facility Telephone Number		

DIRECTIONS: Complete this roster listing all eligible residents for which you are claiming payment. The resident's Medicaid (MA) number must also be listed. Do NOT include Social Security Numbers. Include only those in the program at the end of the report month (must have been in the program for a minimum of 15 days of the month). To be eligible for payment for the month for which you are reporting, this report must be submitted via the Health Commerce System's (HCS's) Secure File Transfer (SFT) within 10 business days of the last day of the report month.

	No. of Residents	Resident's First Name	Resident's Last Name	Admission Date (MM/DD/YYYY)	Resident's MA #
	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
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	10				
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	36				
	37				
	38				
	39				
	40				

Approved Certified Capacity*	
Number of SSI residents in program at the end of the report month*	

(must have been in the program for a minimum of 15 days of the month)

I declare that the information contained in this report is true and accurate and agree that receipt of funds under the Enriched Housing Operating Assistance Program is conditioned upon adherence to the Conditions for Participation for such program as stated in the "ACF EH Operating Assistance Subsidy Application SFY 2020-21"

Print Name (Administrator) _____

Signature _____

Date _____