NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Adult Care Facility Personal Allowance Ledger

FACILITY NAME: ______________________________ OPERATING CERTIFICATE NUMBER: ______________

RESIDENT NAME	DATE OF ADMISSION	DATE ACCOUNT OPENED

DATE (Month/Day/Year)	RECEIPT/PAYMENT NUMBER ON FORM	AMOUNT RECEIVED/DEPOSITED	AMOUNT PAID/WITHDRAWN	**CURRENT BALANCE**

DOH-5193 (DSS-2854) (Revised 11/77, 6/14, 10/15, 12/15)