NEW YORK STATE DEPARTMENT OF HEALTH
Division of ACF/Assisted Living Surveillance

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DATE (Month/Day/Year)	RECEIPT/PAYMENT NUMBER ON FORM	AMOUNT RECEIVED/DEPOSITED	AMOUNT PAID/WITHDRAWN	CURRENT BALANCE