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

Adult Care Facility Personal Allowance Summary

PAGE NUMBER

DATE RECORDED (Month/Day/Year)	RECEIPT FORM NUMBERS (Deposits)	PAYMENT FORM NUMBERS (Withdrawals)	PERSONAL ALLOWANCE		Current Balance BROUGHT FORWARD $.
			RECEIPTS (Deposits) Monthly Total Amount	PAYMENTS (Withdrawals) Monthly Total Amount	