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

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	