TEXAS
Department of Aging
and Disability Services

Date
Worker
Office Address and Telephone No.

On , I visited your facility to monitor a sample of your resident trust funds. My findings and corrective action you are required to take are described on the attached deficiency form.

The purpose of monitoring the resident trust fund system is to determine if your facility is holding, safeguarding and accounting for the recipients' personal funds according to the **Nursing Facility Requirements for Licensure and Medicaid Certification (§19.401).** Future audits completed at your facility may include the deficiencies that I have identified and they may find exceptions that I have not identified.

☐ **Please provide written notification to me when you have completed the necessary corrective action; include any requested documentation.**

☐ **I will return to your facility on _____ to determine if you have corrected the identified discrepancy(ies).**

In accordance with the **Nursing Facility Requirements for Licensure and Medicaid Certification** (§19.2314), if your facility does not make the required correction(s) within the next 60 days, we will recommend that a hold be placed on your Title XIX funds until such time as the required corrections are completed.

Should you care to informally appeal any deficiency determination resulting in punitive action, you may do so by making a written request within 15 days to: Texas Department of Aging and Disability Services, Provider Services/Institutional Services (Mail Code W-535), P.O. Box 149030, Austin, TX 78714-9030. Scheduled hearings will be held in Austin, Texas.

If you have any questions, please call me at the telephone number indicated above.

Sincerely,

Department of Aging and Disability Services

Trust Fund Monitoring Findings

Name of Facility		
Discrepancy (recipient name, if applicable)	**Standards**	**Corrective Action**