

**Monthly Certification Form for Paid Neighbor Services**

PAID NEIGHBOR: \_\_\_\_\_

PARTICIPANT: \_\_\_\_\_

MONTHLY STIPEND AMOUNT: \_\_\_\_\_

I understand the service of Paid Neighbor as outlined in the Paid Neighbor Agreement.

I hereby certify that for the month of \_\_\_\_\_ (Month/Year), the Participant was living independently, and the Participant and Paid Neighbor both remained living within 30-minute travel distance of each other. I was available to the Participant according to the details outlined in the Paid Neighbor Agreement.

\_\_\_\_\_  
Paid Neighbor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant/Representative Signature

\_\_\_\_\_  
Date

(Signing and submitting false information may lead to a charge of Medicaid fraud)

**Note:**

E-mail this document to [payroll@issny.org](mailto:payroll@issny.org) on the last day of the month of service and payment will be made the following month.