***INSTRUCTIONS:*** This is a two-page form. Use the worksheet of income and expenses to develop the consumer’s monthly budget and the following page to detail checks are to be written monthly. Attach additional copies of any page as needed and provide complete, clear information. Attach bills or other info such as vendor names/addresses/phone numbers. This budget takes the place of the previous budget – list ALL regular monthly payments needed on each budget.

SCAN & Email or FAX THIS AND ALL FOLLOWING PAGE(S) TO BFC RPP AT (202) 265-1970.

|  |  |  |
| --- | --- | --- |
| **Consumer’s Residential Address:** |  | |
|  | **Washington, DC ZIP:** |  |
| **Consumer’s Home Phone:** |  | |

|  |  |
| --- | --- |
| **MONTHLY INCOME MANAGED BY BFC** | |
| **Source** | **Amount** |
| **Supplemental Security Income (SSI)** |  |
| **Social Security Disability Income (SSDI)** |  |
| **Civil Service Annuity/Pension (OPM)** |  |
| **TOTAL MONTHLY INCOME:** |  |

|  |
| --- |
| **Does the consumer have any other income outside of BFC? 🞏 YES 🞏 NO** If yes, please attach proof. |

|  |  |
| --- | --- |
| **MONTHLY EXPENSES** | |
| **Description** | **Monthly Total** |
| **CRF Room & Board Fee** |  |
| **Personal Needs Allowance**  includes all regular out-of-pocket expenses, snacks, transportation, hygiene, etc. |  |
| **Bills To Be Paid Separately** (if any)  **Medication Co-Pay**  **Insurance Premium**  **Other:** |  |
|  |
|  |
|  |
| **Desired Monthly Savings** - for future clothing, holidays, birthdays, etc |  |
| **MONTHLY TOTAL:** |  |

**Total expenses should not exceed monthly income unless there is savings that will be spent down.**

|  |  |
| --- | --- |
| **CURRENT SAVINGS BALANCE @ BFC:** |  |

**Provider / Community Support Worker Completing this Form:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | Phone |  | | Email: |  |
| Supervisor Name | |  | | | Supervisor Email: | |  |

**CRF ROOM & BOARD FEE**

|  |  |  |
| --- | --- | --- |
| Amount: | Complete Vendor Name: | |
| **$1,454.00\*\*** |  | |
| Date of Payment | Complete Vendor Address: | |
| **1st** |  | |
| Info for check memo: | | Vendor Phone: |
| **CRF Rent for** | |  |
| Check delivery method: | **🞎** By mail to address listed above 🞏 include in Agency Batch 🗹 Direct Deposit | |
|  | 🞏 Pick-up from NW Center by**:** | |
| Comments/Special Instructions: **\*\*BFC will pay the** **standard CRF rate as set and amended by** | | |
| **DC government agencies or the rate billed by the CRF operator ($1454 = rate for 2023)** | | |

**EXPENSE MONEY/ SPENDING ALLOWANCE**

|  |  |  |  |
| --- | --- | --- | --- |
| Frequency | Amount | Pay to: | 🗹 Consumer |
| 🞏 Complete Vendor Name: |
| 🞎 Monthly |  | Delivery method: 🞎 By mail – write address below in Comments | |
| Twice Monthly | include in Agency Batch – Agency/Team**:** | |
| 🞏 Weekly (x5) | 🞎 Pick-up from NW Center by:­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 🞏 Other: | 🗹 Direct Deposit to PNC Debit Card or personal account | |
| Comments/Special Instructions: | | | |
|  | | | |

**OTHER MONTHLY BILLS** *Whenever possible, utility bills should be mailed directly to BFC for payment in full upon receipt. Please provide a copy of the actual bill for reference.*

|  |  |  |
| --- | --- | --- |
| Complete Vendor Name: | | 🞏 pay in full upon receipt of bill |
|  | | Estimated maximum amount: |
| Complete Vendor Address: | | Monthly due date: |
|  | | 🞏 bill mailed to BFC |
| Account Number: | | 🞏 consumer will bring in bill |
|  | **OR** 🞏 pay this amount: $ | |
| Check will be mailed to vendor unless otherwise specified below. | At the beginning of each month | |
| Comments/Special Instructions: | | |
|  | | |

|  |  |  |
| --- | --- | --- |
| Complete Vendor Name: | | 🞏 pay in full upon receipt of bill |
|  | | Estimated maximum amount: |
| Complete Vendor Address: | | Monthly due date: |
|  | | 🞏 bill mailed to BFC |
| Account Number: | | 🞏 consumer will bring in bill |
|  | **OR** 🞏 pay this amount: $ | |
| Check will be mailed to vendor unless otherwise specified below. | At the beginning of each month | |
| Comments/Special Instructions: | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| **CSW Signature** (**required**) | **Date** | **Clinical Team Supervisor** (**required**) | **Date** |
|  | |  | |
| **Consumer Signature** (preferred) | | **Date** | |