Bread for the City – Representative Payee Program
Income and Expense Worksheet & Monthly Spending Plan

Consumer _____ **DOB** _____ **Provider Agency** _____

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**
Rent/Mortgage/Storage Unit	
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:** _____

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Rent/Mortgage/Storage Unit

Amount:	Complete Vendor Name:	
Date of Payment	Complete Vendor Address:	
Info for check memo:		Vendor Phone:
Check delivery method:	□ By mail to address listed above □ include in Agency Batch □ Direct Deposit	
	□ Pick-up from NW Center by**:**	

EXPENSE MONEY/ SPENDING ALLOWANCE

Frequency	Amount	Pay to: □ **Consumer** □ Complete Vendor Name:
□ Monthly □ Twice Monthly □ Weekly (x5) □ Other:		Delivery method: □ By mail – write address below in Comments □ include in Agency Batch – Agency/Team: _____ □ Pick-up from NW Center by:_____ □ Direct Deposit to True Link 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: Monthly due date: □ bill mailed to BFC □ consumer will bring in bill
Complete Vendor Address:	
Account Number:	**OR** □ pay this amount: at the beginning of each month
Check will be mailed to vendor unless otherwise specified below.	
Comments/Special Instructions:	

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

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