

FOR CRF
RESIDENTS
ONLY

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

2026
\$1534 CRF
\$141 PNA

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
CRF Room & Board Fee	\$1534.00
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:	\$
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Provider / Community Support Worker Completing this Form:

Name _____ Phone _____ Email: _____
Supervisor Name _____ Supervisor Email: _____

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CRF ROOM & BOARD FEE

Amount: \$1,534.00**	Complete Vendor Name:	
Date of Payment 1st	Complete Vendor Address:	
Info for check memo: CRF Rent for	Vendor Phone:	
Check delivery method:	<input type="checkbox"/> By mail to address listed above	<input type="checkbox"/> include in Agency Batch
	<input type="checkbox"/> Pick-up from NW Center by:	<input type="checkbox"/> Direct Deposit
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 (\$1534 = rate for 2025)		

EXPENSE MONEY/ SPENDING ALLOWANCE

Frequency	Amount	Pay <input checked="" type="checkbox"/> Consumer to: <input type="checkbox"/> Complete Vendor Name:
<input type="checkbox"/> Monthly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Weekly (x5) <input type="checkbox"/> Other:		Delivery method: <input type="checkbox"/> By mail – write address below in Comments include in Agency Batch – Agency/Team: <input type="checkbox"/> Pick-up from NW Center by: _____ <input type="checkbox"/> 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:	<input type="checkbox"/> pay in full upon receipt of bill Estimated maximum amount: Monthly due date: <input type="checkbox"/> bill mailed to BFC <input type="checkbox"/> consumer will bring in bill
Complete Vendor Address:	
Account Number:	
Check will be mailed to vendor unless otherwise specified below.	OR <input type="checkbox"/> pay this amount: \$ At the beginning of each month
Comments/Special Instructions:	

Complete Vendor Name:	<input type="checkbox"/> pay in full upon receipt of bill Estimated maximum amount: Monthly due date: <input type="checkbox"/> bill mailed to BFC <input type="checkbox"/> consumer will bring in bill
Complete Vendor Address:	
Account Number:	
Check will be mailed to vendor unless otherwise specified below.	OR <input type="checkbox"/> pay this amount: \$ At the beginning of each month
Comments/Special Instructions:	

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