Adult Mental Health Division
Representative Payee Program

Monthly Budget Sheet

Consumer Name:_____ Month/Year:_____

Source of Income	Date Received	Amount
G.A. (General Assistance)		
SSI (Supplemental Security Income)		
SSDI (Social Security Disability Insurance)		
Wages/Employer:		
Other (Specify)		
Food Stamps		
Total Received for Month		

Monthly Expenses	Notes (paid to, terms, &/or acct #'s)	Amount
Rent		
Storage Fee		
Utilities		
Phone		
Cable TV		
Food/Clubhouse Meals		
Medical/Dental		
Taxi Coupons		
Allowance		
TOTAL Expenses		

Total Monthly Income ( ) – Total Monthly Expense ( ) = (monthly savings)

I understand that the allowance amount shown on this form will be given to me as indicated above. Any budget changes need to be reviewed with my CM and forwarded to my RP via Change of Event Report.

_____ _____ _____

Consumer Signature Case Manager Name (Printed) Case Manager Signature

_____ _____ _____

Representative Payee Name RP Signature Date

Recommendation: Continue RP services___ Decrease / Maintain RP services (2x Monthly)____
(Circle One)