

SPENDING PLAN

Individual's Name: _____ Date: _____

The Spending Plan must be completed for individuals for whom DES/DDD is the representative payee and/or for individuals living in licensed residential settings. If follow-up is needed, identify action(s) needed and person(s) responsible on the *Action Plan* (DDD-0219A).

SOURCES OF INCOME			
Source	Amount	Frequency	Payee
SSI <i>Note: Do not list Social Security Number</i>	\$		
SSA <i>Note: Do not list Social Security Number</i>	\$		
Earnings	\$		
Other:	\$		
Other:	\$		
ASSETS			
Fund or Property	Value/Balance	As of/Date	Custodian
DES Account	\$		
Group Home Account	\$		
Personal Bank Account	\$		
Other:	\$		
Other:	\$		
EXPENSES			
Type of Expense	Amount	Frequency	Comments
Rent/Room & Board	\$		
Personal Spending Money	\$		
Clothing	\$		
Special Occasions	\$		
Medical/Dental	\$		
Other:	\$		
Other:	\$		
Other:	\$		
Other:	\$		
Other:	\$		
Other:	\$		
Other:	\$		

Is the person responsible for his/her own money? Yes No

Does the guardian or payee want to receive a copy of the person's financial ledger or receipts? Yes No

If yes, how often? _____

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local