MASTER TRUST EXPENDITURE PLAN

Date Plan Prepared: Click or tap to enter a date.

Lead Agency Representative: _____ **Client Name:** _____

Agency / County: _____ **Client Date of Birth:** _____

Email Address: _____ **Client FSFN ID:** _____

Account Balance(s)

Current Needs Account	$ _____	As of Date:	Click or tap to enter a date.
Monthly Accumulation	$ _____	X 3	$ _____
Less Cost of Care	$ _____	X 3	$ _____
Total excess for upcoming 3 months:			$ _____

Client Special Needs:

Medical: _____

Mental: _____

Educational: _____

PASS Plan in Effect: ☐ Yes ☐ No

PASS Plan Appropriate for Child: ☐ Yes ☐ No

Plan to meet needs of child (formal or informal)

Monthly Expenses:	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
Anticipated Expenses:	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____

List participants in development of Expenditure plan below:

_____ _____

_____ _____

_____ _____

_____ _____

Child Welfare Professional Signature: _____ Date Signed: _____

Child Welfare Professional Supervisor Signature: _____ Date Signed: _____