MASTER TRUST EXPENDITURE PLAN

Date Plan Prepared: _____

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:	
Monthly Accumulation	$	X 3	$ 0.00
Less Cost of Care	$	X 3	$ 0.00
Total excess for upcoming 3 months:			$ 0.00

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: _____