**CLIENT DRIVEN SUPPORT**

**EXPENDITURE PLAN for FAMILY SUPPORT GRANT**



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | For supports starting: | | |  | | | | to | | | |  | |
|  | | | | |  | | | | Approved by: | | | | |  | | | |
|  | | | | |  | | | | Date: | | | | |  | | | |
| Client Name: | |  | | | | | | | | | Date of Birth: | | | | |  | |
| Client Address: |  | | | | | | | | | | | | | | | | |
| Parent/Guardian: | |  | | | | | | | | | Telephone: | | | | |  | |
| Worker Name & Number | | | |  | | | | | | | | | | | PMI #: | |  |
| Annual Budget: | | | | | | $ | Monthly Grant Amount: | | | | | | $ | | | | |
| Budget this Year: | | | $ | | | | Email: | | |  | | | | | | | |

**PLEASE COMPLETE #1 and #2 BELOW:**

|  |  |
| --- | --- |
| 1. | DESCRIPTION OF CLIENT/DISABILITY (Include age, disability, description of needs as they relate to child’s disability and what is beyond caring for a typical child of the same age): |
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| 2. | HOW HAS THE FSG GRANT HELPED THE CLIENT IN THE LAST YEAR? |
|  |  |
|  |  |
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| --- | --- | --- | --- | --- |
| **SECTION I**  Below, state what you would like to purchase, projected cost, and why/how it relates to disability of recipient. Write down other services received by recipient and who is paying (i.e. ProAct-school, OT &/or PT-private insurance, etc.) All expenditures must be approved on plan prior to purchase/use of funds.  See CDS Expenditure Guide for parameters of spending. | | | | |
| **SUPPORT** | Persons or agencies hired to provide support, training, and/or assistance for the client, caregiver or staff. |  |  |  |

|  |  |
| --- | --- |
| **INFORMAL:** (unlicensed persons, associated expenses, support for family/primary care givers) | Amount this Year |
|  |  |
| **Informal Total:** |  |

|  |  |
| --- | --- |
| **FORMAL:** (agencies/licensed individuals) | Amount this Year |
|  |  |
| **Formal Total:** |  |
|  |  |
| **Support Total:** |  |

|  |  |  |
| --- | --- | --- |
| **GENERIC SERVICES** | (Please itemize) Services available to the general public are generic services. | Amount this Year |
|  | |  |
| **Generic Services Total:** | |  |

|  |  |  |
| --- | --- | --- |
| **GOODS** | (Please itemize) Goods are items purchased – the “stuff”. | Amount this Year |
|  | |  |
| **Goods Total** | |  |

|  |  |
| --- | --- |
| **GRAND TOTAL** |  |

When receiving a direct cash grant, records of time worked and reimbursed expenses, as well as receipts/bills for other expenditures must be retained by recipient’s parents for 5 years. Read and sign participation agreement. Call your worker if you have any questions.

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| Client/Parent/guardian/Conservator  Signature | Date |  | Social Worker Signature | Date |