



Expenditure Plan for Family Support Grant

Name of Applicant:

Date of Birth:

Parent/Guardian Name:

Preferred Method of Communication (email or mail):

Address:

Phone:

Email:

Case Manager, if applicable:

Email:

Adjusted gross income from most recent tax return:

FSG Date Span: to

FSG Total Amount:

FSG Payment Option:

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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Description of Client/Disability (continued):

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 individual

SUPPORT

Persons or agencies hired to provide support, training, and/or assistance for the client, caregiver or staff.

Supports (Informal & Formal): (unlicensed persons, associated expenses, support for family/primary care givers, and licensed providers)

Disability Related Item with Explanation	Amount this Year
Supports Total	



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Generic Services (Please itemize) Services available to the general public are generic services.

List requested purchase, projected cost, and disability related need.

Disability Related Item with Explanation	Amount this Year
Generic Services Total	



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By signing this, you are agreeing to the following:

- All services and items purchased on this grant are related to the child's disability
- Any spending will match the FSG plan, unless a plan change is made
- Receipts will be saved by parent/guardian for 3 years
- A record of the spending will be maintained and reported on the FSG Expenditure Report Form
- All information within this application is accurate and true

Client/Parent/Guardian Signature

Date

Social Worker Signature

Date