995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

Representative Payee Monthly Finance Plan

_____
Participant First Name, Middle Initial, Last Name

_____
Participant Social Security Number

_____
Participant Date of Birth

_____
Participant Address

Benefits Received:
SSI _____ Amt. per month? _____
SSA_____ Amt. per month? _____
SSDI_____ Amt. per month? _____
DTA Amt. per month? _____ Day of Deposit _____

Rent amount? _____ Payable to _____

_____

_____

Charge for Care amount? _____ Payable to _____

_____

_____

Electric amount _____ Payable to _____
Gas amount _____ Payable to _____
Phone amount _____ Payable to _____
Cable amount? _____ Payable to _____
Other _____ Payable to _____
Other _____ Payable to _____
Other _____ Payable to _____

*Maximum Spending Allowed? _____ AT A TIME / DAY / WEEK / MONTH
(This amount should be the amount defined in participants pstp or per the agreement signed by participant. If this amount changes, you must notify Fiscal immediately. Please read Financial Management Policy.)

_____ _____
Signature of Person filling out the form Date

THIS FORM DOES NOT GENERATE RECURRING CHECKS. PLEASE USE REQUEST TO AMEND MONTHLY FINANCE PLAN FORM.