



MASTER TRUST EXPENDITURE PLAN

Date Plan Prepared: _____
Lead Agency
Representative: _____
Agency / County: _____
Email Address: _____

Client Name: _____
Client Date of Birth: _____
Client FSN ID: _____

Account Balance(s)

Current Needs Account	\$ _____	As of 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: _____