PARTICIPANT PERSONAL FUNDS REPORT

Participant's Name_____Month_____

Date	Savings Deposit	Savings Withdrawal	Balance Previous Month _____	Checking Deposit	Checking Withdrawal	Balance Previous Month _____	Cash On Hand Description of Use	Amount of Cash on Hand	Amount of Cash Used	Balance Forwarded from Previous Month _____

End of Month Balance_____

**Receipts must be attached to this ledger
for expenditures which exceed $5.00

**Allowable participant expenditures: personal items such as clothing, deodorant, shampoo, haircuts, tobacco products, dry cleaning and shaving products (NOT soap, toothpaste, toothbrush, or dental cleaner), room and board charges, entertainment expenses, gifts for family and/or friends, money used for visiting family and/or friends, medical co-payments, and other related items which are needed by the consumer and are not included as a benefit of the Medicaid program.

Participant Signature_____ Date_____

HH Provider Signature_____ Date_____

HH Coordinator Signature_____ Date_____