**Sanilac County Community Mental Health Authority**

**INDIVIDUAL FUNDS PART I**

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|  Name: | Case #: |
| Home or Program Name & Address |
| **Instructions:**1. Both Residential and Program Providers are to complete Sections A, B, and C; for any individual for whom funds are received and held.
2. Providers must complete an “Individual Funds Part II’ form for any individual’s funds or account(s) held or managed by the Provider including: personal funds or allowance, savings or checking accounts, cash or checks received, interest or dividends, stocks or bonds, money market funds or certificates of deposit, and all other applicable funds.
3. Providers are to keep the “Individual Funds Form Part I” and “Individual Funds Form Part II” in the individual’s record.
4. **Providers are required to send a copy of the “Individual Funds Form Part I” and “Individual Funds Form Part II” to the person(s) responsible for managing this individual’s funds at least quarterly or sooner if the sheet is full.**
5. Providers shall not commingle individual’s funds with the Provider’s funds.

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| **Section A –** The person(s) responsible for this individual’s funds is: |
| \_\_\_\_ Individual |
| \_\_\_\_ Legal Guardian | Name: | Phone #: |
| \_\_\_\_ Representative Payee  | Name: | Phone #: |
| \_\_\_\_ Provider or Designee | Name: | Phone #: |
| \_\_\_\_ Other | Name: | Phone #: |
|  |
| **Section B –** Please indicate below all applicable accounts managed by the Provider or their Designee. All transactions regarding these accounts must be recorded on a “Individual Funds Form Part II” form. Name of the individual managing account: -------------------------------------------------------------------------------------- |
| \_\_\_\_ Cash |  |  |
| \_\_\_\_ Checking-Joint Checking  | Name of Bank:  | Account #: |
| \_\_\_\_ Savings-Joint Savings  | Name of Bank: | Account #: |
| \_\_\_\_ Other Account  | Name of Bank: | Account #: |
| Signature of Joint Account Holder (1) | Signature of Joint Account Holder (2) |
|  |
| **Section C –** I certify that I have no ownership interest in the individual’s account(s) |
| Provider/Designee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_ |   |

THIS REPORT WAS SENT TO THE RESPONSIBLE PARTY ON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STAFF INITIALS\_\_\_\_\_

Distribution: Original - Home or Program Record Copy – Person responsible for Individual