CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR AGING
Budget Request Form

CLIENT INFORMATION

X Revised Budget
(put a "X" if Revised)

Name of Client: PHANNA ROEUN **Effective date:** 11/01/23 *(mm/dd/yy)*

Name of Placement: FAITH HARBOR SCL FAMILY HOME **Phone#:** 270-202-8173

Address: 3201 YEARLING AVE *(Street)* BOWLING GREEN *(City)* Kentucky *(State)* 42101 *(zip)*

Type of Placement: SCL **Private Pay** N/A **Other:**

INCOME

	Monthly		Monthly	
SSA:	843.00	VA:		
SSI:	91.00	Pension:		
PA:		Other (Specify):		(Railroad, Black Lung, Retirement)
		Estimated Wages	120.00	
		Total Income:	**$ 1,054.00**	

EXPENSES

		Weekly	Biweekly	Monthly	Summary
Facility/Rent:	FAITH HARBOR			$ 565.00	565.00
Address:	PO BOX 151 ROCKFIELD KY. 42274				
Personal Needs:	FAITH HARBOR			$ 100.00	100.00
Address:	PO BOX 151 ROCKFIELD KY. 42274				
Grocery Funds:					-
Address:					
Average Utilities:					-
Address:					
Wage Allowance:	FAITH HARBOR			$ 100.00	100.00
Address:	PO BOX 151 ROCKFIELD KY. 42271				
Insurance Premiums:					-
Address:					
Pharmacy Co-pays					-
Address:					
Restitution:					-
Address:					
Other (Specify):					-
Address:					
Other (Specify):					-
Address:					
Other (Specify):					-
Address:					

Brief Notes: *(Text will automatically wrap within the given space)*

Total Expenses: $ 765.00

Net Gain $ 289.00

GSSW TRINITY HALEY, GSSC II 10/18/2023 *(Date)*

FSOS: Ashlee Alexander, GFSOS 10/18/2023 *(Date)*