

SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
PERSONAL FUNDS DRAFT (PFD)

Person's Name: _____

Date: _____

Social Security Number: _____

Residence: _____

I want/need \$_____ of my personal funds.

I want/need \$_____ of my personal funds spent for me to: _____

Additional Information: _____

Make check payable to: _____

Signed: _____
 (Person)

Address (optional): _____

Requested By: _____ / _____
 (Staff Representative) Date

Approved: _____ / _____
 (Program Administrator) Date

(Necessary only if over \$200)

Approved: _____ / _____
 (Residential Manager of QID/DDP) Date

Approved: _____ / _____
 (Facility Administrator/
 Executive Director) Date

(Necessary only if over \$500)

Funds Verified & Encumbered: _____
 (Regional Bank Liaison)

Paid in: Cash or by Check #: _____

Paid By: _____
 (Cashier)

Date _____

Received By: _____
 (Staff Representative)

Date _____

I certify that the above mentioned withdrawn funds were either given to or expended for the sole benefit of the above named person, with the exception of \$_____ in unspent funds that I am returning to the Regional Bank.

 (Staff Representative) Date

 (Regional Bank Liaison) Date

Regional Bank (1st Copy)
 Certification (2nd Copy)
 Residence (3rd Copy)

For posting purposes after disbursing funds.
 For Regional Bank audit records after purchases are made and unspent funds, if any, are returned to the Regional Bank for deposit (within 2 business days).
 For residence staff after certification signature of Regional Bank Liaison has been obtained.