

**MONTHLY ACCOUNT** of the estate of [Name of Mentally Incapacitated Person]

**Month/Year:                    /                    *(completed monthly)***

Income		Expenditure			
Items	Amount	Items	Amount	Receipts	
				Yes	No
1. Social Security Allowance	\$	1. Nursing Home Fee/Rental	\$		
2. Pension	\$	2. Diaper Fees	\$		
3. Interest/Dividend <i>(e.g. Bank accounts/Shares)</i>		3. Medical expenses <i>(e.g. medical consultation, hospitalization fees, physiotherapist charges, etc)</i>			
(1)	\$	(1)	\$		
(2)	\$	(2)	\$		
(3)	\$	(3)	\$		
4. Rental Income <i>(list address of the properties)</i>		4. Domestic helper	\$		
(1)	\$	5. Private nurse	\$		
(2)	\$	6. Food	\$		
5. Proceeds from selling of shares/properties		7. Transport	\$		
(1)	\$	8. Utilities (e.g. electricity, gas, rates, telephone, water)	\$		
(2)	\$	9. Other expenses <i>(please specify)</i>			
6. Contributions from family members	\$	(1)	\$		
7. Others <i>(please specify)</i>		(2)	\$		
(1)	\$	10. Repayment of Debts			
(2)	\$	(1)	\$		
		(2)	\$		
<b>Total:</b>	<b>\$</b>	<b>Total:</b>	<b>\$</b>		

Signed by the Committee: \_\_\_\_\_

Date: \_\_\_\_\_

(\*Please keep all the invoices or receipts and provide copies to the Court)