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. Diaper Fees	$		
2. Pension	$	3. Medical expenses *(e.g. medical consultation, hospitalization fees, physiotherapist charges, etc)*			
3. Interest/Dividend *(e.g. Bank accounts/Shares)*		(1)	$		
(1)	$	(2)	$		
(2)	$	(3)	$		
(3)	$				
		4. Domestic helper	$		
4. Rental Income *(list address of the properties)*		5. Private nurse	$		
(1)	$	6. Food	$		
(2)	$	7. Transport	$		
		8. Utilities (e.g. electricity, gas, rates, telephone, water)	$		
5. Proceeds from selling of shares/properties		9. Other expenses *(please specify)*			
(1)	$	(1)	$		
(2)	$	(2)	$		
6. Contributions from family members	$				
		10. Repayment of Debts			
7. Others *(please specify)*		(1)	$		
(1)	$	(2)	$		
(2)	$				
Total:	**$_____**	**Total:**	**$_____**		

Signed by the Committee:_____

Date:_____

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