SAN GABRIEL/POMONA
REGIONAL CENTER

Cash Handling

Facility Name: _____ **Date:** _____

Client Name: _____ **UCI#:** _____

This form is to determine and document the amount of cash that a client can handle. This shall remain effective until revoked in writing by the Service Coordinator. **Note:** Client's signature still required for each cash disbursement.

Client can receive up to $ _____ **cash** *(Client signature required)*

X _____ _____
Service Coordinator Signature *Date*

X _____ _____
Facility Administrator Signature *Date*

X _____ _____
Client's Signature *Date*