

**Montana Mental Health  
Nursing Care Center**

**Personal Finance Permission**

This is to certify that the Montana Mental Health Nursing Care Center has my permission to assist me in managing my personal finances which pertain to accounts held at the Montana Mental Health Nursing Care Center.

I authorize the Montana Mental Health Nursing Care Center staff to open business mail necessary to manage resident care.

I Do \_\_\_\_\_ I Do Not \_\_\_\_\_ wish to receive a monthly statement of transactions for my account.

\_\_\_\_\_  
Signature of Resident/Guardian/DPOA/Other

\_\_\_\_\_  
Printed Resident Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness (Staff Member)