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CHARITABLE TRUST GRANT REQUEST FORM

Name of **Beneficiary**: _____

Beneficiary receives: ___ SSI ___ Medicaid ___ Other

Requested by Representative:

Representative Telephone Number: (_____) _____ - _____

Representative E-Mail: _____

PURPOSE: which must be for or on the behalf of the Beneficiary: (Detail information)

AMOUNT \$ _____

Payable to: _____

Address: _____

(ACH: **For personal reimbursement only**)

Bank Name: _____

Routing Number: _____ Account Number: _____

Under penalties of perjury, I declare that to the best of my knowledge and belief, this information is true, correct and complete.

Representative
Signature: _____

Date: _____