2820 Columbiana Road, Suite 103 Vestavia, AL 35216
Phone: 205.313.3915 | Fax: 205.313.3946
Email: info@alabamafamilytrust.com

REQUEST FOR DISBURSEMENT

Name of **Beneficiary**: ____

Beneficiary receives: ____ SSI ____ Medicaid ____Other ____No Benefits

Requested by Representative:

____

Telephone Number: (_____) _____-________ E-Mail: ______________________

Payable to: ____

Address: ____

AMOUNT $_______________

(ACH: For personal reimbursement only)

Bank Name: ____

Routing Number: _______________________ Account Number: ______________________

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

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: _______________

 Rev 04-2019