Alabama Family Trust
ADMINISTERING SPECIAL NEEDS TRUSTS

2820 Columbiana Road, Suite 103 Vestavia, AL 35216
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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: _____