100 Centerview Drive, Suite 200 | Vestavia Hills, AL 35216
Phone: 205-883-8333 | Fax: 205-883-0333 | info@alabamafamilytrust.com

REQUEST FOR DISBURSEMENT

NAME OF **BENEFICIARY**: _____

BENEFICIARY RECEIVES (MUST CHOOSE AT LEAST ONE):

_____ SSI _____ Medicaid _____ No governmental benefits

_____ Other benefits – please specify: _____

NAME OF REPRESENTATIVE: _____

REP PHONE: _____ REP EMAIL: _____

PAYABLE TO: _____

PAYEE ADDRESS: _____

AMOUNT REQUESTED: $ _____

(ACH: FOR PERSONAL REIMBURSEMENT ONLY)

BANK NAME: _____

ROUTING NUMBER: _____ ACCOUNT NUMBER: _____

PURPOSE: Disbursements must be made on behalf of the Beneficiary. Please provide detailed information about the purpose of the requested disbursement. For example, if you are requesting a disbursement for cell phone service for the beneficiary, but the household uses a family plan, please request only the amount due for the beneficiary's portion of the service and provide a copy of the bill showing the beneficiary's portion of the bill.

_____

_____

DOCUMENTATION ATTACHED (INVOICE, ESTIMATE, ADVERTISEMENT, RECEIPT, ETC.): _____

PROOF OF PAYMENT IF PERSONAL REIMBURSEMENT:

CREDIT CARD INFORMATION _____ ATTACHED _____ ON FILE

BANK ACCOUNT INFORMATION _____ ATTACHED _____ ON FILE

Under penalty of perjury, I declare that to the best of my knowledge and belief, the information contained in this Request is true, accurate, and complete. I understand that false or incomplete information could affect the Beneficiary's eligibility for certain benefits programs. I understand and agree that any refund of any disbursement made for the Beneficiary must be returned to AFT for depositing back into the Beneficiary's trust account.

Representative Signature: _____ Date: _____