ALABAMA FAMILY TRUST
Administering Special Needs Trusts

100 Centerview Dr., Suite 200, Vestavia Hills, AL 35216

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RequestforRecurring Disbursements

Name of **Beneficiary**: _____

Beneficiary receives: SSI _____Medicaid _____Other _____ No Benefits _____

Requested by Representative:_____

Telephone number: _____ e-Mail: _____

Payable to: _____

Address: _____

_____

Average Bill Amount: _____ Max Amount Authorized: _____

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

_____

_____

I, _____, request that Alabama Family Trust make monthly payments to the above payee in the amount of _____. This amount may fluctuate each month depending on services provided by vendor. I request that the board approve to pay for those fluctuations up to the max amount of _____.

Under penalty of perjury, I declare that, to the best of my knowledge and belief, this information contained in this Request is true, correct, 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 will need to be returned to AFT for depositing back into the Beneficiary's trust account.

Representative Signature: Date: _____

_____

Name:

_____