Security for People with Special Needs since 1990

office | 804.740.6930 **toll free** | 888.241.6039 **fax** | 804.740.6065
address | PO Box 29408, Richmond, VA 23242-0408
email | PaymentRequest@trustCCT.org

Payment Request Form

Directions: Complete entirely and sign. Requests **must** include an invoice, copy of receipt, or price quote. Incomplete requests will result in delayed processing time. Requests require up to 14 days for processing. Please plan accordingly.

*BENEFICIARY NAME:		*ACCOUNT:	

***MAKE PAYABLE TO:**

Name: ______________________________

Address: ______________________________
Street Address or P.O. Box

____
City State Zip Code

***MAIL CHECK TO:** ☐ Same as above **OR**

Name: ______________________________

Address: ______________________________
Street Address or P.O. Box

____
City State Zip Code

ACCOUNT/INVOICE NUMBER (if applicable): ______________________________

***AMOUNT REQUESTED**: $ ____________________ **DATE DUE:** ______________

***PAYMENT FOR**: ______________________________

____

***Does the Beneficiary receive:** **Supplemental Security Income (SSI)?** ☐ Yes ☐ No
Medicaid? ☐ Yes ☐ No

***SSI Recipients Only:** Please check that this request does not include payment for food, shelter or reimbursement: ☐

Signer certifies the following: 1) I am authorized to make disbursement requests on behalf of the Beneficiary, 2) the requested disbursement is for the sole benefit of the Beneficiary, 3) I will pay back to the trust any expenses found to be duplicates, not for the benefit of the Beneficiary, or incurred after the death of the Beneficiary, 4) I will follow SSI/Medicaid rules for reporting changes to the Beneficiary's financial situation within 10 working days (SSI/Medicaid recipients only).

*Requested By: ____________________ ____________________ ____________
(Print Name) (Signature) (Date)

(If 2nd signature is required) ____________________ ____________________ ____________
(Print Name) (Signature) (Date)

***CONTACT INFORMATION** **Telephone:** ______________ **Email:** ______________

Contact CCT immediately about any changes to SSI/Medicaid benefits or about changes to any contact information for either the Advocate or Beneficiary.

Requests can be submitted to CCT via mail, fax, or email to the attention of Payment Request Processor:
CCT, P.O. Box 29408, Richmond, VA 23242 • fax: (804)740-6065 • PaymentRequest@trustCCT.org

OFFICE USE ONLY Request Granted: ☐ Yes ☐ No	Reason:
Authorized By:	Date Authorized:

08/2016 ***REQUIRED**