Center for Disability Rights, Inc.

497 State Street Rochester, New York 14608 (585) 546-7560 V/TTY (585) 546-7567 FAX
PooledTrust@cdrnys.org

Community Supplemental Needs Trust

Contact Form
(Please Print Legibly)

Participant Name: _____

Participant Address: _____

Participant Phone Number:

_____ Home

_____ Cell

_____ Other

Participant Email: _____

If someone else is authorized to handle the participant's money or submit disbursement requests, complete the boxed section of this form. CDR will contact the representative for questions on the account as well as mail the monthly statements to the representative.

Representative Name: _____

Address: _____

Type of Representative (check one):
[ ] Legal Guardian
[ ] Representative Payee
[ ] Other: _____

Representative's Phone Number:

_____ Home
_____ Cell
_____ Other

Representative's Email: _____

Completed by
Signature: _____ **Date:** _____