Center for Disability Rights, Inc.

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PooledTrust@cdrnys.org

Community Supplemental Needs Trust

Disbursement/Withdrawal Form

1. Name and address of the beneficiary (**Person whose name is on trust account**):

   _____

   _____

   _____

2. Amount requested: _____

3. Do you want CDR to pay this bill:
   Every month [ ] **A bill must be submitted each month. Rent payments require a valid Rental Agreement or Lease to be on file. The Disbursement Form is valid for one year.**
   ONE time [ ]

4. Describe what the request is for: _____
   (Examples: Utilities, Phone, Rent, Clothing, Food)
5. If this request is for rent please state the month to be paid_____

6. Name and Address of the business or person to whom the check should be made out:

   _____
   (Name: Business or Person)

   _____
   (Street Address)

   _____
   (City/State/ZIP)

X_____ _____
Signature of beneficiary or legally responsible person Date

With proper documentation and available funds, disbursement processing may take up to 10 business days.
By signing this form, I attest that payment from the trust is being used for the benefit of the trust beneficiary identified on this form and no other individual. I further attest that the funds are not being used for:

- an expense that Medicaid would cover:
- the purchase of firearms, alcohol, tobacco, illegal drugs, or drug paraphernalia; or
- legal fees relating to illegal activities, restitution, bail, credit card debt prior to enrollment in the trust, fees associated with overdrawn bank accounts, debit card charges, or cash advances taken on credit cards.

For Trustee
Use Date approved by Board of Trustees: _____
Approval by trustees of payment to this vendor for this type of purchase will be valid for one year.

FOR INTERNAL USE ONLY

RECEIVED	APPROVAL	DOCUMENTS	FUNDED	ENTERED