SPECIAL NEEDS TRUST FOUNDATION
Distribution Request

Directions: Complete entirely and sign. **Requests must include an invoice/statement, copy of receipt(s), 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: (Write in TRUE LINK if you are requesting additional funds loaded on to your True Link card)

Name: _____

Address: _____

City: _____ State _____ Zip _____

MAIL CHECK TO: ☐ Same as above **OR**

Name: _____

Address: _____

City: _____ State _____ Zip _____

ACCOUNT NUMBER/INVOICE NUMBER (if applicable): _____

AMOUNT REQUESTED: $_____ **DATE DUE:** _____

PAYMENT FOR: _____

RECURRING PAYMENTS ONLY: PAY THIS AMOUNT MONTHLY: ___ for 3 months, ____ for 6 months, ___ for 12 months

Does the Beneficiary receive: Supplemental Security Income (SSI)? ☐ Yes ☐ No Medi-Cal? ☐ Yes ☐ No
Section 8? ☐ 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/Medi-Cal rules for reporting changes to the Beneficiary's financial situation within 10 working days (SSI/Medi-Cal recipients only).

Requested By: _____ _____ _____
(Print Name) (Signature) (Date)

CONTACT INFORMATION Telephone: _____ Email: _____

Contact SNTF immediately about any changes to SSI/Medi-Cal benefits or about changes to any contact information for either the Advocate or the Beneficiary.

Request can be submitted to SNTF via mail, fax, or email:
SNTF, 353 E. Park Ave., Ste. 101, El Cajon, CA 92020 ● fax: (619)312-1554 ● requests@sntf-sd.org

OFFICE USE ONLY Request Granted: ☐ Yes ☐ No Reason:	
Requested Amount to $2,500 Authorized By:	Date:
Requested Amount over $2,500 Approval of Board Required:	Date:

HOW TO COMPETE A DISTRIBUTION REQUEST FORM

To fill out a **Distribution Request Form**, please print or type out all of the following information:

1. Beneficiary Name: The full name of the beneficiary. This is the person for whom the Trust was established and is intended to serve.
2. Account: The complete account number of the beneficiary's account.
3. Make Payable To: The complete business name and address of the "Payee" (the business, organization, or individual to be paid.)
4. Mail Check To: If the check should be mailed directly to the payee, check the box "Same as able." If the check should be mailed to the advocate, beneficiary or other, provide name and mailing address.
5. Account/Invoice Number: If applicable, write in the account, reference or invoice number so that this information can be included when mailing the check (e.g. credit card number or service account number).
6. Amount Requested: The amount requested to be paid to the Payee. SNTF reserves the right to approve a smaller disbursement amount than requested.
7. Date Due: The date by which the payment must be received. Please allow 10 business days from the date the request is received by SNTF for processing and the check to be mailed.
8. Payment For: Sate the purpose of the requests (e.g. cell phone service, medical expense, etc.). Be as detailed as possible.
9. Beneficiary Receives: Indicate the beneficiary's Medi-Cal status and SSI status at the time the *Distribution Request Form* is submitted. Check the Yes box if the beneficiary receives Medi-Cal/SSI benefits; check the No box if the beneficiary does not receive Medi-Cal/SSI. If the beneficiary receives SSI, check the box reimbursement to the beneficiary.
10. Requested By: The printed name and signature of the beneficiary/advocate(s). SNTF may require a second signature for some disbursement requests.
11. Contact Information: The phone number or email address at which the beneficiary/advocate can most easily be reached during business hours (9:00 am – 5:00 pm PTS, Monday through Friday.

REMEMBER YOUR RECEIPTS

- If you are **requesting reimbursement**, please include all receipts totaling the requested amount.
- If you are requesting **funds for a future purchase**, you must include estimates, quotes, invoices, or screenshots itemizing the items or services you are purchasing, and their totals, including any taxes and shipping.

Always include the beneficiary's name and account number on each email, fax, and document submitted to SNTF.