BalancedCare Trust Disbursement Request Form

Directions: Please print below and attach supporting documents for your request. (ex. Copy of invoice, Landlord statement or lease.

Beneficiary Name: _____ Date: _____

Beneficiary Current Address:_____

Phone number: _____

☐ **One-time-only payment**

☐ **Recurring Monthly Payment** ☐ **New** ☐ **Change** ☐ **Discontinue**

Start/End Date _____

Select One: ☐ **Mail Set amount Monthly** ☐ **Hold for Monthly Invoice**

Amount Requested: $_____ (max Amount if holding for Invoice)

Check payable to: _____

Mailing address _____

_____

Please explain briefly purpose of request:

_____

_____

Signature of person Authorizing _____ Date _____

Contact Number _____

Beneficiary Signature(optional) _____ Date _____

Completed forms can be drop off, mailed, faxed or emailed in.

Balanced Care Trust Department
87 North Clinton Ave Suite 2
Rochester, NY 14624
(585)232-1840
Fax: (585)-232-5376