PLAN
Special Needs Trusts

DISBURSEMENT REQUEST FORM

Submit form and attachments via:

Email:	Mail:	Fax:
billing@planofma-ri.org	PLAN of MA & RI 50 Braintree Hill Office Park Suite 110 Braintree, MA 02184	617-795-0589

Please print all information clearly.

Beneficiary Name: _____ Date: _____

Account Number: WTC _____

Please check all current benefits:

□ Medicaid □ Medicare □ SSI □ SSDI □ SSA (Retirement)

□ Housing □ Supplemental Medical Ins./Drug Coverage □ Other:_____

If you have not yet submitted the annual verification letter for each benefit, please submit with this request.

Date of Receipt/Invoice	Vendor/Place of Purchase	Item(s)/Service(s)Purchased	Receipt/Invoice Total	Itemized Receipt/Invoice Attached
				☐
				☐
				☐
				☐
				☐
				☐
☐ **Additional Page Included**		**Total from Additional Page:**		
		Total Amount Requested:		

Make Check Payable to:

_____

NAME ADDRESS CITY, STATE, ZIP CODE

Mail to (if different): _____

☐ Please check box if mailing address has changed since previous disbursement(s) to same recipient.

Request made by:

Name: _____ Phone Number: _____

Email: _____

Relationship to Beneficiary: □ Self □ POA □ Guardian □ Conservator □ Other: _____

I hereby attest, under the pains and penalties of perjury, that the purchase(s) associated with this request were made for the ***sole benefit*** of the Trust Beneficiary.

_____ _____

Signature Date

If there are questions or concerns regarding this request, PLAN staff will contact you.

PLAN strives to mail checks 7-10 business days from receipt of the request.

Updated 4.2026