



The Rhode Island Pooled Trust

HELPING INDIVIDUALS WITH DISABILITIES SAFEGUARD THEIR FINANCIAL FUTURE

Request of Disbursement Form

Trust Participant Name: _____

Date of Request: _____

Person making request: (if different) _____

Phone Number of Person making request: _____

Amount Requested: _____

Reason for request: **Please check**

REIMBURSEMENT

BILL PAY

Attached are receipts I want to be reimbursed for Total:	Attached is a bill I want to have paid Total:
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Signature: _____