

**Lee Guardianship Services, Inc.  
Disbursement Request Form**

Fax to: 866-723-8940

Beneficiary's Name:		Location of Beneficiary: (ex: name and city of facility)	
Advocate's Name:		Advocate's Address:	
Advocate's Phone #:		Investment Account #:	
Benefits (ex: SSI, Medicaid):		Program (ex: nursing home):	
ORIGINAL INVOICE FROM PAYEE MUST BE FAXED WITH THIS FORM. ALL DISBURSEMENTS MUST BE PAYABLE TO A 3 <sup>RD</sup> PARTY AND MUST BE FOR THE SOLE BENEFIT OF THE BENEFICIARY.			
<b>Payee One:</b>		Payee Account #:	
Amount:		Phone #:	
Address:		Payment is for: *Attach separate statement if not enough room.	
I affirm that the above request for payment is for purchases or services for the sole benefit of the beneficiary and affirm that the beneficiary is still living at the time of this request. By my signature, I authorize the Trustee to make payment to the payee in the amount indicated. I understand that if this disbursement compromises the beneficiary's eligibility for government benefits, my request for payment may be denied or may cause a reduction in benefits. If my request is initially denied because of a potential reduction in government benefits and I again request payment, I agree that the Trustee and Charity are not liable for any loss of benefits and agree to hold the Trustee and Charity harmless from any claims or liability.			
ADVOCATE AUTHORIZATION:			
Advocate Name (print):		Advocate Signature:	Date:
LEE GUARDIANSHIP SERVICES, INC. AUTHORIZATION: (TO BE COMPLETED BY TRUSTEE AND CHARITY)			
Signature: Trustee	Date:	Signature: Charity	
<b>Payee Two:</b>		Payee Account #:	
Amount:		Phone #:	
Address:		Payment is for: *Attach separate statement if not enough room.	
I affirm that the above request for payment is for purchases or services for the sole benefit of the beneficiary and affirm that the beneficiary is still living at the time of this request. By my signature, I authorize the Trustee to make payment to the payee in the amount indicated. I understand that if this disbursement compromises the beneficiary's eligibility for government benefits, my request for payment may be denied or may cause a reduction in benefits. If my request is initially denied because of a potential reduction in government benefits and I again request payment, I agree that the Trustee and Charity are not liable for any loss of benefits and agree to hold the Trustee and Charity harmless from any claims or liability.			
ADVOCATE AUTHORIZATION:			
Advocate Name (print):		Advocate Signature:	Date:
LEE GUARDIANSHIP SERVICES, INC. AUTHORIZATION: (TO BE COMPLETED BY TRUSTEE AND CHARITY)			
Signature: Trustee	Date:	Signature: Charity	