THE GEORGIA COMMUNITY TRUST of AADD

REQUEST FOR REIMBURSEMENT

BENEFICIARY: _____ TRUSTEE: _____

AMOUNT TO BE REIMBURSED

CARETAKER (DETAILS ATTACHED) _____
Number of hours worked: _____
Hourly Rate: _____

TRANSPORTATION (RECEIPTS ATTACHED) _____
Gas (Total): _____
Repair/Maintenance (Total): _____
Insurance (Total): _____
% Auto used on behalf of the beneficiary: _____%

SUPPLIES (RECEIPTS ATTACHED) _____

MEDICATIONS (RECEIPTS ATTACHED) _____

ENTERTAINMENT (RECEIPTS ATTACHED) _____

HOUSEHOLD (RECEIPTS ATTACHED) _____
Number of individuals in household: _____
Utilities (Total): _____
Cable: _____ Internet: _____ Telephone: _____
Insurance: _____
Property Tax: _____

OTHER (RECEIPTS ATTACHED) (PLEASE LIST BELOW)

_____ _____ _____

_____ _____ _____

TOTAL TO BE REIMBURSED $_____

Special Mailing Instructions: _____

_____ _____*
DATE SIGNATURE OF TRUSTEE
Contact #: (____)_____-_____

*By signing as trustee, I hereby attest that this reimbursement form accurately reflects the amounts submitted for reimbursement. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that falsification, omission, or concealment of this information may subject the beneficiary to loss of SSI/Medicaid.

_____ _____
DATE APPROVED BY GCT STAFF *Rev. 9/2015*