THE GEORGIA COMMUNITY TRUST of AADD

REQUEST FOR REIMBURSEMENT

BENEFICIARY: _____ CO-TRUSTEE: _____

CARETAKER (Timesheet Attached) **CATEGORY TOTAL S**

Number of Hours Worked: _____

Hourly Rate: _____ _____

TRANSPORTATION (Receipts Attached) % Used on behalf of Beneficiary: _____

Gas/Fuel: _____

Mileage: _____

Repair/Maintenance (Total) : _____

Car Payments (must have lien on file): _____

Insurance/Tag: _____ _____

SUPPLIES (Recipts Attached)

Clothing: _____

Personal Hygiene/Grooming: _____ _____

EDUCATION (Recipts Attached)

Tutition (School, Camps, Classes): _____ _____

MEDICAL AND THERAPIES(Recipts Attached)

Doctor/Medical Visits: _____

Threapy/Rebahbilitation Visits (OP/PT): _____

Medical Supplies: _____

Medications: _____ _____

ENTERTAINMENT (Recipts Attached)

Any dining costs in excess of $20 is considered as income by SSI/SSDI and Medicaid and must be reported monthly.
It is the responsiblitiy of the Co-Trustee to report income.

Movie/Concert Tickets: _____

Dining _____

Cable (Hulu, Netflix, etc.): _____

Internet: _____

Recreational Activities: _____

Other (CD's, Books, Lessons, Hobby, Electronics, etc.) _____ _____

HOUSEHOLD (Recipts Attached) Number in Household: _____

Phone Service/Cell Phone (Beneficiary Only): _____

Household Cleaning Supplies: _____

Maintenance/Repairs/Modifications: _____

The following household expenses are considered as income by SSI/SSDI and Medicaid and must be reported monthly.
It is the responsiblitiy of the Co-Trustee to report income.

Mortgage (must have agreements on file)/Rent: _____

Insurance (must have agreements on file): _____

Property Taxes (must have agreements on file): _____

Electric: _____

Gas/Heating Fuel: _____

Water/Sewer/Garbage: _____ _____

OTHER (Receipts Attached) (Please List Below)

Descriptor	Vendor	Amount

TOTAL TO BE REIMBURSED: $ _____

Special Mailing Instructions: _____

*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 **SIGNATURE OF TRUSTEE**

Address Changed: ☐ No ☐ Yes If Yes, Address: _____

Email: _____ Phone: _____