995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

REQUEST TO ACCESS PARTICIPANT FUNDS

Participant Name:_____

Date of Request: _____ **Date Needed** _____

Program/Site:_____

Reason for Request: _____
_____

(Reason must document that the costs are above and beyond the cost of participant care paid for by state contracts. See Charges for Care Guidelines.)

Amount of Request: $_____
Charge Participant/Guardian? ____ Yes ____No
Pay from Rep Payee Account? ____ Yes ____No

Participant's/Guardian's Signature: _____

Program Director's Signature: _____

Division Director's Signature:_____