**□ Cheque: Pick Up \_\_\_ Mail \_\_\_**

**□ EFT**

**Coast Foundation Society (1974)**

**Trust Fund Requisition**

Amount Requested:

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Amount:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_

Date: Month \_\_\_\_\_\_\_\_ Day\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_

Trust Account Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pay to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province: \_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the nature and purpose of the payment (you may include attachments to this form):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Declaration: I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**declare that the information herein is accurate and**

**I have no income and resources available to me to pay for the amounts requested other than this trust.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Requisitions must be received by 4pm Mondays to have cheques available Thursday.***

***Requisitions can be faxed to 604 879-2363 or emailed to*** ***Trust@coastmentalhealth.com***

 ***\* Note: payment may be delayed or not made at all if the form is incomplete or may result in loss of benefits.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR CFS OFFICE USE ONLY**

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$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  A device or medical aid related to your health or wellbeing  *………………………………….………..*

[ ]  Caregiver Services or other services related to the beneficiary’s disability  *…………....……………*

[ ]  Education or Training  *……………………………………………………………….………..…………….*

[ ]  Necessary maintenance of your home  *………………………………….……………………..…………*

[ ]  An item or service necessary to promote your independence ………………………………..………*...*

[ ]  Item which the expenditure is not considered “income” under the BC Benefits Act Disability Program .

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signatory

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signatory