DISABILITY TRUST CLOSURE FORM

Please complete this form whenever a Medicaid client with an approved disability trust becomes ineligible for Medicaid. Please send the form to:

Brian Zolynas
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203-1818
Fax: (303) 866-3552 **Phone: (303) 866-5410**

County:	
County Technician Name:	
Phone Number:	
Fax Number:	
Date:	

Name of Medicaid Client:	
State ID, SSN, or CBMS ID:	
Date of Medicaid Ineligibility:	
Reason for Medicaid Ineligibility:	
Date of Death (if applicable):	
Disability Trust Trustee Name:	
Disability Trust Trustee Address:	

- Please include a copy of any statements or accountings you have received for the trust.
- Please include a copy of the executed (signed) trust.

ADDITIONAL INFORMATION OR EXPLANATION: