



COLORADO
Department of Health Care
Policy & Financing

NOTIFICATION OF TRUST DISTRIBUTION

The trustee of a disability trust should use this form to provide notice of any trust distribution in excess of \$5,000. This notice is required under Colorado law, and may be provided prior to the distribution or no later than thirty (30) days after the distribution. At the trustee's discretion, the trustee may also use this form to provide notice of any other trust distributions.

Name of Client (Primary Beneficiary): _____

Client's State ID or SSN: _____

Trustee Name: _____

Trustee's Address: _____

Trustee's Phone Number: _____

Trustee's Email: _____

Date of Distribution: _____

Amount of Distribution: _____

Does the trust have any remaining funds or other assets? **Yes / No**

Description of items or services received:

Note: If supporting documentation was not previously provided to the Department, please include copies of any necessary supporting documentation with this notice (e.g. receipts, invoices, agreements, contracts, deeds, titles, and/or any other documentation evidencing ownership if real property or vehicles are purchased).

Please mail, fax, or email this notice and a copy of supporting documentation to:

Colorado Department of Health Care Policy and Financing
Attn: Trust Unit
1570 Grant Street
Denver, Colorado 80203-1818
Fax: (303) 866-3552
Email: Medicaid.Trusts@state.co.us