TO SUBMIT THIS FORM
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40 N. Main St., Ste. 500
Dayton, OH 45423

THE DISABILITY FOUNDATION

LOST RECEIPT FORM

Beneficiary:	**Personal Rep (PR):**
	PR Phone:
Date:	**PR Email:**
Benefits (✓ all that apply): ☐ **SSI** ☐ **SSDI** ☐ **MEDICAID TYPE _____**	

From time to time, receipts are lost, misplaced, destroyed, or never received. This form must be completed for any receipts missing after funds have been made available for the benefit of the Beneficiary.

By signing this form, I certify that:

- ☐ I paid the amounts on the dates listed to the Business/Individuals outlined in Section I below.
- ☐ The itemized receipt for this payment has been lost or was not received from the vendor and that this statement is given in lieu of that itemized receipt.
- ☐ The missing receipts or invoices represent legitimate expenses incurred solely for the benefit of the Beneficiary.
- ☐ I will maintain all receipts to the best of my ability in the future.
- ☐ **I understand future disbursements may be denied if proper receipts are not provided.**

SECTION 1: List the item(s), Business/Individual who received payment and the amount paid			
Item/Service Description	Date	Business/Individual	Amount
1.			
2.			
3.			
4.			
5.			
		TOTAL	$

☐ *I acknowledge that the funds were used for the sole benefit of the Beneficiary of the sub-account.*

SIGNATURE of Personal Representative: _____ DATE: _____

Please allow **5-8 business days for processing**. Incomplete forms will be returned to the Personal Representative.
FEEL FREE TO MAKE COPIES OF THIS FORM. VISIT OUR WEBSITE TO DOWNLOAD THIS FORM.
www.disability-foundation.org