CLC, Inc. Pooled Trust 3
135 Radio Circle Drive Suite 208 Mount Kisco, New York 10549
(P) 914.244.9688 (F) 914.244.9689

www.adicares.org

TRUST DISTRIBUTION FORM

Date: ______________________________

Beneficiary: ______________________________

In the space provided below please list the amount of each check . ADiCares must schedule payments at least 7 business days advance of the scheduled due date to ensure they arrive in a timely manner. **Please also attach the bill for each request.**

Bill	Vendor Account Number	Amount
1. ____________________	____________________________	$___________
2. ____________________	____________________________	$___________
3. ____________________	____________________________	$___________
4. ____________________	____________________________	$___________
5. ____________________	____________________________	$___________

Total amount of request: $______________________ **(For Office Use Only)**

Signature of Authorized Requestor: ____

Contact Information of Authorized Requestor (check preferred):

☐ Email: ____

☐ Phone: ____