



**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: Please include a copy of all receipts and/or invoices. If the distribution is for the purchase of a residence or vehicle, please also include a copy of the deed or title. If the distribution is for caregiver services, please include a copy of the caregiver agreement or contract.**

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](mailto:Medicaid.Trusts@state.co.us)