

	Reque	st for Trillium F	Reserve Payment Form	
Participant Name			Participant ID #	
Employer Nam	10]	
Payment Instru	ctions			
Make Check P	ayable To:			
Name			Is this payment to an Employee?	No
Address			City/State/Zip	
Trillium RTrillium Rdate shou	ıld be within pay period o eserve – Training, use th	in total miles X rate in the gross amount of t of pay cycle in which y		
Service Date	Service Code	Description		Total Amount
	Mileage			
	Bonus			
	Training			
			Total Check Amount	
			Invoice Number (if applicable)	
	Return th	is form to Acumen by	email to payroll-nc@acumen2.net	
REMIN	IDER: Please be sure to ch	neck the amount remain pay more than i	ing in your Trillium Reserve allotment. Acu is remaining.	ımen cannot
and/or approved the claim may be from Fo statements or docum	above payment request in a ederal and State funds, and	ccordance with the Prog that I may be prosecuted aterial fact. Any misuse	onsistent with the Individualized Support Pla ram regulations. I understand that payment I under applicable Federal or State laws, for of funds may result in being fined or penaliz y responsibility.	and satisfaction of this any false claims,
EOR Signature			Date	
If you are requesting	ng a reimbursement to th	e Employer, this form	must also be signed by a representative	ve of Trillium Health

Acumen Fiscal Agent, LLC 5416 E. Baseline Rd., Suite 200 Mesa, AZ 85206 Phone (866) 811-3099 Fax (855) 264-3292 Payroll-nc@acumen2.net