

**State of Connecticut
Department of Correction
Inmate Trust Fund
24 Wolcott Hill Road
Wethersfield, CT 06109
Fax: (860) 692-7894**

Request for Account Balance Form

Section I – Completed by Inmate

In order to claim remaining funds from Inmate Trust Fund, this form must be completed in its entirety.

Discharging
DOC Facility: _____ Date of Discharge: _____

Inmate Name: _____ Inmate # : _____
Please print

Date of Birth: _____

Inmate Mailing
Address: _____
'In Care Of', if applicable

Complete Street Address including **bdg., Apt. #**

City State Zip Code

Inmate Signature: _____ Date: _____

Section II – Completed by Staff

Per A.D. 3.7 – Inmate Monies, Section 13 Closed Accounts: Upon notice of release or discharge and receipt of authorizing documentation, a check for the inmate's account balance shall be prepared. The check shall be mailed to an address provided by the inmate. The inmate may receive the check upon discharge at the facility if 30 days notification is provided.

Staff Signature: _____ Date: _____