The Arc
Northern Virginia
Special Needs Trust
Serving Virginia, MD & DC

The Arc of Northern Virginia
3060 Williams Drive, Suite 300, Fairfax, VA 22031
Phone: 703-208-1119; Fax: 703-982-7135
www.thearcofnovatrust.org

<u>RECURRING</u> Disbursement Request Form

Beneficiary Name: ____________________ **Participant #:** __________

Check Payee: ____________________ **Account #:** __________

Mail Check to: ____________________
____

Payment Amount: $____________________

Check Memo:
(i.e. Account #) ____________________

Purpose of Request: ____________________

Frequency: Please check one and specify payment due date:

- ☐ Yearly: __________
- ☐ Every 6 months: __________
- ☐ Quarterly: __________
- ☐ Monthly: __________
- ☐ Other: __________

Does the Beneficiary Receive - Medicaid? ☐ Yes ☐ No
- SSI? ☐ Yes ☐ No

<u>Remember:</u> SSI Recipients may not use their trusts to pay for food, shelter or direct reimbursement; if receiving Medicaid, direct reimbursement is also not guaranteed given income limitations.

Please enclose copies of bills, statements, training invoices or receipts.

NOTE:
Each business day, Disbursement Requests are processed in the order in which they are received by The Foundation of The Arc of Northern Virginia. **<u>Complete</u>** and **<u>legible</u>** Disbursement Requests with sufficient supporting documentation will be reviewed within **<u>8 business days of receipt</u>**. Emergency situations will be addressed individually.

The Arc sends aproved Disbursement Request to the Trustee. Upon receipt the Trustee will print and issue payment to the Payee within **<u>5 business days</u>**.

Disbursement requests may require additional review and/or documentation. Certain expenses may require prior submission to and denial by a government agency to be considered a legitimate supplementary expense.

The Foundation of The Arc of Northern Virginia has sole discretion regarding disbursements for the Beneficiary.

Requested By (print): ____________________ **Phone/Email:** ____________________

Title (if appropriate): ____________________

Signature: ____________________ **Date:** ____________________

By signing this form, the Primary Representative is certifying:
1. He/she is authorized to approve Disbursement Requests on behalf of the Beneficiary;
2. This Disbursement Request is for the sole benefit of the Beneficiary;
3. The Beneficiary was alive at the time the expense was incurred (for SF trusts only);
4. The Beneficiary will follow SSI and Medicaid rules for reporting changes in income within 10 business days.

ARC ONLY:

__FIXED or ___ VARIABLE

- ○ **Approved** Date: ____________________
- ○ **Disapproved:** Reason ____________________ Date: ____________________
- ○ **Pending:** Reason____________________ Date: ____________________

Signature: ____________________