



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: 703-208-0906
www.thearcofnovatrust.org

RECURRING 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

Remember: SSI Recipients may not use their trusts to pay for food, shelter or direct reimbursement.

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. **Complete** and **legible** Disbursement Requests with sufficient supporting documentation will be reviewed within **8 business days of receipt**. Emergency situations will be addressed individually.

The Arc sends approved Disbursement Request to the Trustee. Upon receipt the Trustee will print and issue payment to the Payee within **5 business days**.

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: _____