The Arc of Northern Virginia
2755 Hartland Road, Suite 200, Falls Church, VA 22043
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 approved **within 5 business days of receipt**. Emergency situations will be addressed individually.

Generally, once The Arc sends the Disbursement Request to the Trustee, the Trustee will process the DR, then print and mail the check 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: ________________________