

TO SUBMIT THIS FORM
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DISBURSEMENT REQUEST FORM

Beneficiary:	Primary Rep (PR):
Sub-Account Number:	PR Phone:
Date:	PR Email:
Benefits (✓ all that apply):	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> MEDICAID TYPE _____
For SSI recipients only: This request does not include payment for items related to food, shelter or cash <input type="checkbox"/>	

SECTION 1: Please list the item(s) and/or service(s) for which a disbursement is requested.	
Item/Service Description	Amount
1.	
2.	
3.	
4.	
5.	
<input type="checkbox"/> ADVANCE <input type="checkbox"/> REIMBURSE	TOTAL \$ _____

If you have more items/services to list please attach another Disbursement Request Form.

SECTION 2: Payment Options (Choose only one: Check, Direct Deposit or True Link Card)	
<input type="checkbox"/> Check	Make Check Payable To: _____ Memo on Check (e.g. Invoice or account number): _____ <u>Mail Check To:</u> Name: _____ Address: _____ City: _____ State: _____ Zip: _____
<input type="checkbox"/> Direct Deposit	Bank Name: _____ Bank Phone: _____ Account Holder's Name: _____ Checking <input type="checkbox"/> OR Last 4 Digits of _____ Savings <input type="checkbox"/> Bank Account Number: _____
<i>A Disbursement Direct Deposit Authorization Form MUST be completed or be on file for a direct deposit to be made.</i>	
<input type="checkbox"/> True Link Card	Name of Card Holder: _____ Last 4 Digits of the Card: _____

☆ YOU MUST ATTACH A COPY OF ALL RECEIPTS ☆

By signing this I acknowledge that this is for the sole benefit of the Beneficiary of the sub-account.

SIGNATURE of Primary Representative: _____ DATE: _____