

TO SUBMIT THIS FORM
 E-Mail: Trust@thearcoftexas.org
 FAX: 512-454-4956
 MAIL: 8001 Centre Park Drive, Suite 100
 Austin, Texas 78754



AUTOMATIC PAYMENT REQUEST FORM

MUST BE SUBMITTED 30 DAYS IN ADVANCE OF DUE DATE

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"/>	

The Primary Representative authorizes the Master Pooled Trust to set up an automatic payment to be withdrawn from the sub-account. To cancel or make changes to an automatic payment, a minimum of 30 days' notice is required and the Primary Representative must submit a new Automatic Payment Request Form to the Master Pooled Trust. Two changes to automatic payments per year is allowed before being counted toward Frequent Disbursement Request Fees.

Choose One: START CHANGE CANCEL/END

MONTH THE AUTOMATIC PAYMENT SHOULD START: _____

AMOUNT TO BE PAID (must be the same amount every period): \$ _____

PAYMENT IS **DUE** ON THE _____ OF EACH MONTH WEEK

DISBURSEMENT DESCRIPTION: _____

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): _____
	Mail Check To:
	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 Bank Account Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Savings <input type="checkbox"/>
<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: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

☆ 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: _____

Please allow 5-8 business days for processing. Incomplete forms will be returned to the Primary Representative.
 VISIT OUR WEBSITE TO DOWNLOAD OR COMPLETE THIS FORM ONLINE: www.thearcoftexas.org/trust-forms