

Enrollment Fee Disbursement Request Form

Beneficiary Name: _____

Check Payee: Foundation of The Arc of Northern Virginia

Mail Check to: 3060 Williams Drive, Suite 300, Fairfax, VA, 22031

Payment Amount: \$ _____

Check Memo: Enrollment Fee

Beneficiary Receives:
Medicaid: Yes No

SSI: Yes No

Remember: SSI Recipients may not use their trusts to pay for food, shelter or direct reimbursement.
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Requested By (print): _____

Phone/Email: _____

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.
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ARC ONLY:

- Approved**

Signature: _____ **Date:** _____