Disbursement Request for Respite Care, Attendant Care and/or Companion Service

Name of Caregiver/Attendant/Companion _____

Company Name _____

Mailing Address _____

Phone Number _____

Social Security Number or EIN of Caregiver _____

I am requesting that Arcare, Inc., as Trustee, disburse funds from the beneficiary trust share for the benefit of the below named Beneficiary. The disbursed funds will be used to cover the cost of services arranged for the Beneficiary as indicated below.

Due to SSA guidelines the company/person(s) selected must have professional training. Copies of certifications may be requested.

Arcare, Inc. has not been involved in selection, scheduling, training, supervising, providing instruction or otherwise controlling the work of the caregiver. I understand that Arcare, Inc. is not employing the caregiver and is not responsible for a withholding or paying federal, state, or local income tax, or payroll tax of any kind on behalf of the caregiver. I also understand that Arcare, Inc. does not provide any insurance coverage (including workers' compensation) for the caregiver.

Date	Service Provided	Hours	Hourly Rate	Cost
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
			Total Amount Due	$0.00

_____ _____

Signature of Caregiver/Attendant/Companion Date

Incomplete forms will not be processed and will be returned to the beneficiary.

(Beneficiary is the person for whose benefit the trust has been established.)

_____ _____

Name of Beneficiary (please print) Phone Number

_____ _____

Signature of Beneficiary/POA/Guardian/Designee Date

Mail, fax or email this completed form to:
8417 Santa Fe Drive | Suite 107 | Overland Park, KS 66212
Fax: 913.648.0057 Email: info@arcare.org

arcare
Planning today for your loved one's tomorrow

For internal use only.

Approved by _____ Date _____ *Rev. 8/14*