Request For Distribution

Please choose ONE of the following disbursement types:

☐ **PAY A BILL** *(Vendor is the name of the company or person to whom payment will be made.)*

Vendor ________________________ Mail to ________________________

Vendor's Address ________________________ ________________________

________________________ ________________________

Amount ________________________ ☐ Check if *Mail to* information is the same as Vendor

Reason for bill or service provided (cable, phone, medical, etc.) ________________________

Additional Information ________________________

☐ **ORDER AN ITEM**

Name of Store or Website ________________________

Address (Website or Location) ________________________

Describe items in detail. You may attach additional pages, as well as a printed website shopping cart.

Item Description	Item # or SKU	Amount

(Tax and standard shipping will be added to the total order) **Total Amount** ________________

Ship to Address ________________________

Additional Information ________________________

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

For internal use only.

Approved by ________________________ Date ________________ *Rev. 8/14*