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:

PO Box 12890 | Overland Park, KS 66282

Fax: 913.648.0057 Email: info@arcare.org

For internal use only.

Approved by ______________________ Date ______________ *Rev. 2/18*