STIMULUS MONEY REQUEST

Requests will be reviewed within 7-10 business days from receipt

Client Information

Client_______________________________________ Mail to _______________________________________

Client Address _______________________________ _______________________________________

_______________________________________ _______________________________________

Phone: _______________________________________ ☐ check if Mail to information is the same

Additional Information ____

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REQUEST DETAIL (PLEASE INCLUDE ALL INFORMATION)

How the funds will be disbursed (check or True Link card) _______________________________________

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

Reason for bill or service provided (cable, phone, medical) Amount

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Total Amount _______________________________

Additional Information____

Signature of Client/POA/Guardian/Designee __________________________________ Date _________________

For internal use, only:

☐ Approved or ☐ Not Approved by: _____________________________ Date ____________________________

Reason: ☐ Not enough information ☐ Included in weekly SM ☐ Cannot afford with current budget ☐ Already Paid ☐ Forward to Trust ☐ Other (Explain on back)

Please mail request to: **Arcare, Inc.**
PO Box 12890
Overland Park, KS 66282

For Internal use only:

Received on:

- OR - fax request to: **(913) 648-0057**