Form A-100

Monthly Electronic Deposit Form

Contact Details

Beneficiary Name: _____ Account #: _____
(leave blank for new accounts)

Contact Phone: _____ Contact Email: _____

Name of Authorized Signer on Account: _____
(if other than the Beneficiary)

Recurring Monthly Deposit Details

*For spend-down deposits, the amount must be **equal to or greater than** the excess monthly income determined by Medicaid. Do not estimate, refer to the Medicaid Notice of Decision.*

Choose Monthly Deposit Day (circle one): 1 4 6 8 11 15 18 22 25

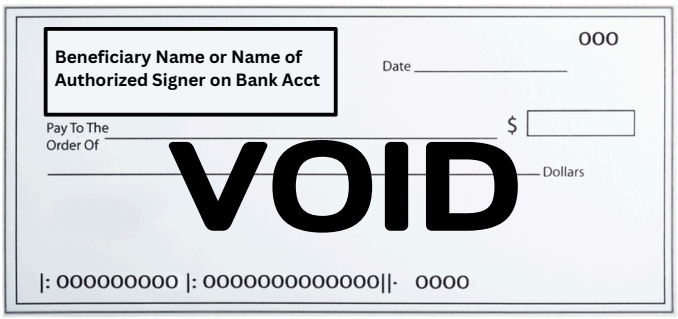
Month to Begin: _____

Monthly Deposit Amount: _____

Account Type:
☐ Checking ☐ Savings

Monthly Deposit Request: ☐ New ☐ Change ☐ Delete

Attach a voided check or letter/statement from bank indicating the account and routing #. Changes to your deposit amount do not require a new check copy. If signing as an agent, attach a copy of the Power of Attorney (POA) unless one is already on file.



Submit **complete and signed** forms to:

ATTN: Accounting
Online at: portal.nysarctrustservices.org
Existing Accounts: trustrequest@nysarc.org
New Accounts: intake@nysarc.org
Fax #: (518) 439-2670
Mail: PO Box 1531, Latham, NY 12110

☐ ***I am an authorized signer on this bank account requesting to initiate monthly recurring deposits.***

_____ _____
Signature of Authorized Signer of Bank Account **Date**

*I authorize NYSARC Trust Services to initiate recurring monthly ACH withdrawals from my bank account as specified in this authorization. If a scheduled withdrawal date falls on a weekend or a bank holiday, the withdrawal will be initiated on the next business day. I understand that any changes to this authorization must be submitted in writing at least **10 business days prior** to the next scheduled withdrawal date. In the event an ACH transaction is rejected due to **Insufficient Funds (ISF)**, I authorize NYSARC Trust Services, at its discretion, to attempt to process the charge again within **30 days**, and I agree to a **$25 fee** for each such attempt. I agree not to dispute these transactions with my bank as long as they conform to the terms set forth in this authorization. Should I dispute a transaction in violation of this agreement, I understand that NYSARC Trust Services reserves the right to pursue legal action to recover any resulting overdraft or negative balance.*

Monthly E-Deposit Form Instructions

Authorized Signer on Account: Clearly print the name of the authorized signer on the bank account who is completing this form, if other than the beneficiary.

Monthly Deposit Day: Clearly indicate what day of the month you would like the funds withdrawn from the bank account each month. If the date selected falls on a weekend or holiday in a particular month, the funds will be withdrawn on the next business day.

Month to Begin: Clearly indicate the month you would like deposits to begin. We must receive this form and have your account set up at least 10 business days before date selected to begin monthly deposits on time.

If setup cannot be completed by the selected date, deposits will start the following month. As a courtesy, we'll try to contact you to arrange a one-time e-Deposit or request a mailed check until monthly deposits begin.

Deposit Amount: Clearly indicate the amount to be withdrawn for the bank account on a monthly basis. For deposits of excess income, the amount must be equal to or greater than your monthly spend-down.

- **Please ensure all fields are accurate and complete. Missing or incomplete information may delay processing.**
- **See submission instructions below and attach copy of a voided check or bank letter on a separate page.**
- **To change a monthly deposit, allow 5-10 business days for processing**
- **To stop monthly deposits, contact us immediately at (518) 439-8323**

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ATTN: Accounting

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New Accounts: intake@nysarc.org

Fax # (518) 439-2670

Mail to: PO Box 1531 Latham, NY 12110

For questions or assistance, please call (518) 439-8323.