

NYSARC Trust Services

Monthly Electronic Deposit Form

Beneficiary name: _____

Account Code: _____

Authorized individual submitting form (see instructions): _____

NOTE: This form is not intended for one-time deposits. Please only use this form if you are interested in having the amount below withdrawn from your account on a monthly basis.

Requested monthly deposit date: **1 4 6 8 11 15 18 22 25**

Month to begin: _____ **Account Type:** **Checking Savings**

Requested deposit amount: \$ _____ **New Change Delete**

Signature of bank account holder

Date

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify NYSARC Trust Services in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next withdrawal date. If this communication is not received 15 days prior, requested changes may not go into effect prior to the withdrawal date. If the above noted periodic withdrawal date falls on a weekend or holiday, I understand that the payment will be executed on the next business day. In the case of an ACH transaction being rejected for Nonsufficient Funds (NSF), I understand that NYSARC Trust Services may at its discretion attempt to process the charge again within 30 days, and I agree to an additional \$25.00 charge for each attempt. I agree not to dispute this billing with my bank so long as the transactions correspond to the terms indicated in this authorization form. Should I do so, I understand that NYSARC Trust Services may take legal action to remediate any resulting overdraft or negative balance. I attest that the amount of the requested deposit includes the beneficiary's monthly spenddown as per Medicaid.

Attach Voided Check Here

A voided check from your bank account **MUST** be included in the initial application
and for changes in bank account.
(Do not use a deposit ticket or temporary check)

Mail to:

Attn: Accounting
NYSARC Trust Services
PO Box 1531
Latham, NY 12110



Fax or Email to:

(518) 439-2670, Attn: Accounting
trustrequest@nysarc.org

TRUST SERVICES OFFICE USE ONLY

Date Received in Accounting: _____

Date added to ACH System: _____

Added by (staff name): _____

Approved by and date: _____

Pre-note sent: _____

Monthly Electronic Deposit Form – Instructions

Beneficiary name: Please clearly print the beneficiary's name in blue or black ink.

Account code: Please clearly print the beneficiary's NYSARC trust account number.

Authorized individual submitting form: Please clearly print the name of the person submitting the form if other than the beneficiary. This individual must be an **authorized signer** on the savings or checking account.

Requested monthly deposit date: Please clearly indicate what day of the month you would like the funds withdrawn from your personal bank account each month for deposit into your trust account.

NOTE: 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: Please clearly indicate the month in which monthly electronic deposits should begin.

NOTE: Please mail a physical check to the address on your deposit slip as usual in the month you submit this Monthly Electronic Deposit Form. The earliest date your monthly electronic deposits will begin is the month following receipt of your Monthly Electronic Deposit Form. Please allow up to **15 days** for processing.

For example: for monthly electronic deposits to begin on the 4th of a specific month, NYSARC must receive the form no later than the 20th of the previous month (assuming a 30 day month).

Account type: Please clearly indicate the type of account from which the funds will be withdrawn.

Requested deposit amount: Please clearly indicate what amount should be withdrawn from your personal bank account for deposit into your trust account. This is generally the amount of your monthly spenddown.

Signature of bank account holder: Must be an authorized signer on the checking or savings account. If signing electronically, you cannot simply type your name. Open the form in a PDF viewer such as Adobe Acrobat and follow the prompts to sign with a Digital Signature ID. Otherwise, print and sign the form.

Please fax, email or mail the completed form to the locations noted on the first page of this form. If you are faxing or emailing the form, please send the copy of the check as a separate page or attachment.

When requesting a change to your monthly electronic deposit, allow 7 days for processing changes to the deposit amount and 15 days for processing changes to the bank account.

NOTE: If the beneficiary will no longer be making deposits, **please contact our Customer Service Department immediately.**

For additional inquiries, please contact our Customer Service Department at (518) 439-8323 or visit our website: www.nysarctrustservices.org