MARC (First-Party) Special Needs Pooled Trust Application
APPLICANT'S DISABILITY INFORMATION

Applicant's Disability:
- Developmental/Cognitive
- Mental Illness
- Neurological
- Physical
- Other (Please Specify): __________________________________________________

Applicant's Medical Diagnoses:
- __________________________________________________

PLEASE NOTE: DISCLOSURE OF DISABILITY AND DIAGNOSIS ABOVE IS ESSENTIAL.

Has the Social Security Administration (SSA) made a determination of disability?
- Yes
- No

If yes, please list the date of determination: ___________________________________________

Is the applicant applying to SSA for a disability determination?
- Yes
- No
- Not Certain

APPLICANT'S BENEFITS INFORMATION

Please complete all items below by selecting either YES or NO. For any items checked YES, please indicate the monthly amount and provide supporting documentation.

Health Coverage:
- Medicaid/MassHealth?  Yes  No  Applying
- Medicare?  Yes  No
- Medicare Prescription Drug Coverage?  Yes  No
- Private Health Insurance?  Yes  No
- Dental Insurance?  Yes  No

Income & Benefits:
- Supplemental Security Income (SSI)?  Yes  No  Amt/month: $
- Social Security Disability Income (SSDI)?  Yes  No  Amt/month: $
- Social Security (Retirement)?  Yes  No  Amt/month: $
- Wages?  Yes  No  Amt/month: $
- Retirement Fund?  Yes  No  Amt/month: $
- Veterans Affairs Benefits?  Yes  No  Amt/month: $
- SNAP Benefits?  Yes  No  Amt/month: $
- Annuity?  Yes  No  Amt/month: $
- Long Term Care Insurance?  Yes  No  Amt/month: $
- Other? Specify:  Yes  No  Amt/month: $

TRUST COMMUNICATIONS

Where should mailings about the trust, including bank statements and tax documents, be sent?

Recipient's Name: __________________________________________

Mailing Address: __________________________________________

Email Address: __________________________________________

Two Adams Place Suite 110, 859 Willard St. Quincy, MA 02169 | 331 Waterman Street, Ste. 225W, Providence, RI 02906
Phone: 617-244-5552 | 401-234-8444  Fax: 617-795-0589  E-mail: info@planofma-ri.org
Last update: 4.1.2024  Page 2 of 10
**APPLICANT’S RESIDENTIAL & WORK/DAY SETTINGS**

In what setting does the beneficiary primarily reside?:
- [ ] Private Housing
- [ ] Group Home
- [ ] Specialized Foster Care
- [ ] Nursing Home
- [ ] Assisted Living Facility
- [ ] Other – Please Specify:

Work/Day Setting:
- [ ] Employment – full-time
- [ ] Employment – part-time
- [ ] None
- [ ] Day Program
- [ ] Other – Please Specify:

Providers (if applicable):
- Residential Provider: (Name) (Address)
- Day Program Provider:

If the applicant is living in an institutional setting, is he/she expected to return to a community-based setting?  □ YES  □ NO  If YES, please provide an anticipated date: ___________________

If YES, please provide a copy of the short term approval letter.

Does the applicant receive a housing subsidy of any kind?  □ YES  □ NO
If YES, what type and how much money is received per month? _____________________________
________________________________________________________________________________

Is the applicant currently on a waiting list for a housing subsidy?  □ YES  □ NO

Has the applicant ever lived in another state?  □ YES  □ NO
If YES, please list the state(s) and date(s) of residence:

<table>
<thead>
<tr>
<th>State</th>
<th>Date(s) of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REAL PROPERTY**

Does the applicant own any real property?  □ YES  □ NO
If YES, please check the appropriate box below and provide a copy of the deed:
- [ ] The property is currently occupied by someone other than the applicant
- [ ] The property is being used as rental income
- [ ] The property is vacant pending its sale
- [ ] Other (please explain) ____________________________________________________________

Please provide the address of the property: ______________________________________________
________________________________________________________________________________
### Applicant’s End-of-Life Arrangements

Does the applicant have a pre-paid funeral/burial contract?

- [ ] YES (If so, please submit copy)
- [ ] NO

Does the applicant have a Will?

- [ ] YES (If so, please submit copy)
- [ ] NO

### Life Estate Information

Does the applicant have a life estate in any real property?

- [ ] YES
- [ ] NO

If yes, please provide the address of the property and a copy of the life estate:

________________________________________________________________________________

**NOTE:** Please include with your application the following important documents:

- POA/Conservator/Guardian – Copy of appointment
- Benefits – Copy of health insurance cards (Masshealth, Medicare A & D, Private health insurance)
- Income – Copy of most recent bank statement or income statement from SSA
- Real Property/Life Estate – Copy of deed. Copy of life estate

*(please continue application on next page)*
### SECTION II: SIGNOR AND REPRESENTATIVE INFORMATION

#### POWER OF ATTORNEY INFORMATION

If the applicant has a Power of Attorney/Attorney-in-Fact, whether or not the Applicant needs the Power of Attorney to sign the Application, please complete this section.

Please submit a copy of the Power of Attorney with the application. Additionally, if the beneficiary has a Will, please submit a copy of the Will with the application.

<table>
<thead>
<tr>
<th>POA’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>POA’s Address:</td>
<td>(Street) (City, State) (Zip Code)</td>
</tr>
<tr>
<td>POA’s Phone(s):</td>
<td>(Home) (Cell) (Other-Please Specify)</td>
</tr>
<tr>
<td>POA’s E-Mail</td>
<td></td>
</tr>
</tbody>
</table>

#### CONSERVATOR INFORMATION

If the applicant has a court-appointed guardian or conservator, please complete this section.

Please note: If the GUARDIAN or CONSERVATOR will be signing trust documents on behalf of the beneficiary, please submit the following with this application: Decree of Guardianship/Conservatorship, Petition to Establish an Estate Plan, and the Court Order approving the petition.

<table>
<thead>
<tr>
<th>Conservator’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservator’s Address:</td>
<td>(Street) (City, State) (Zip Code)</td>
</tr>
<tr>
<td>Conservator’s Phone(s):</td>
<td>(Home) (Cell) (Other-Please Specify)</td>
</tr>
<tr>
<td>Conservator’s E-Mail(s):</td>
<td></td>
</tr>
</tbody>
</table>
GUARDIANSHIP INFORMATION

If the applicant has a guardian, please complete this section.

Guardian’s Name:

Guardian’s Address:

(Street) (City, State) (Zip Code)

Guardian’s Phone(s):

(Home) (Cell) (Other-Please Specify)

Guardian’s E-Mail(s):

SIGNOR INFORMATION

Who will be signing the trust documents? (Please select one.)

☐ Beneficiary  ☐ Beneficiary’s Conservator/Guardian  ☐ Beneficiary’s Power of Attorney

REPRESENTATIVE PAYEE

If the applicant has a representative payee, please complete this section. Note: A representative payee is a person or organization that has been appointed by the Social Security Administration to receive the Social Security or SSI benefits of a beneficiary who is believed to be incapable of managing his or her own benefits.

Rep Payee’s Name:

Rep Payee’s Address:

(Street) (City, State) (Zip Code)

Rep Payee’s Phone(s):

(Home) (Cell) (Other-Please Specify)

Rep Payee’s E-Mail(s):
SECTION III: FUNDING & DISBURSEMENTS

<table>
<thead>
<tr>
<th>FUNDING THE TRUST ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Deposit to Trust:</strong> (Approx.)</td>
</tr>
<tr>
<td>Note: If under $10,000, contact PLAN</td>
</tr>
<tr>
<td><strong>Subsequent Deposit(s):</strong> (if applicable)</td>
</tr>
<tr>
<td>Note: If under $10,000, contact PLAN</td>
</tr>
</tbody>
</table>

Were any of the funds above subject to a Medicaid or Medicare lien? ☐ YES ☐ NO

Please Note: If YES, submit evidence with the application demonstrating that the lien has been satisfied.

DISBURSEMENTS

After the trust account is established, PLAN’s Service Coordinator will contact the beneficiary or a representative of the beneficiary to develop a spending plan and discuss the process for accessing funds. Who should be contacted for this purpose?

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
<th>Email:</th>
<th>Relationship to Beneficiary:</th>
</tr>
</thead>
</table>

Note: PLAN, as Trustee, has total and sole discretion in making payments from an individual’s trust account. All payments must be for the sole benefit of the trust beneficiary.

SECTION IV: ATTORNEY INFORMATION (if applicable)

<table>
<thead>
<tr>
<th>APPLICANT’S ATTORNEY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attorney’s Name:</strong></td>
</tr>
<tr>
<td><strong>Attorney’s Address:</strong> (Street) (City, State) (Zip Code)</td>
</tr>
<tr>
<td><strong>Attorney’s Phone(s):</strong> (Work) (Cell) (Other-Please Specify)</td>
</tr>
<tr>
<td><strong>Attorney’s E-Mail:</strong></td>
</tr>
</tbody>
</table>

Will this attorney be involved with the beneficiary on an ongoing basis? ☐ YES ☐ NO
SECTION V: REMAINDERPERSONS

Provide the name of the person(s) or entity(ies) who the beneficiary wishes to receive any funds remaining after the beneficiary’s death after final settlement costs, after the 10% (Beneficiary dies within two (2) years of joining the trust) or 20% (Beneficiary dies more than two (2) years after joining the trust) remainder to PLAN, and after all Medicaid claims have been paid or settled. Specify what percentage of the remaining funds you wish each to receive. Percentages must total 100%.

*Please notify PLAN of change in address or contact information for the remainderpersons.*

**Primary Remainderperson/Organization 1**

Name: __________________________________________

Address: _________________________________________

Contact Information: _______________________________

% of Remaining Funds: ______________________________

If this remainderperson does not survive the beneficiary, what should happen to his/her share? (Check one.)

☐ Share to be distributed to other (living) primary remainderpersons listed on this form, in proportion to their respective beneficial interest.

☐ Distribute this share to this remainderperson’s descendants.

☐ Distribute this share to someone else:

Name: ____________________________  Address: ____________________________

(Street)  (City, State)  (Zip Code)

(Phone Number)  (E-mail Address)

**Primary Remainderperson/Organization 2**

Name: __________________________________________

Address: _________________________________________

Contact Information: _______________________________

% of Remaining Funds: ______________________________

If this remainderperson does not survive the beneficiary, what should happen to his/her share? (Check one.)

☐ Share to be distributed to other (living) primary remainderpersons listed on this form, in proportion to their respective beneficial interest.

☐ Distribute this share to this remainderperson’s descendants.

☐ Distribute this share to someone else:

Name: ____________________________  Address: ____________________________

(Street)  (City, State)  (Zip Code)

(Phone Number)  (E-mail Address)
Primary Remainderperson/Organization 3

Name: ____________________________________________

Address: ____________________________________________

(Street) (City, State) (Zip Code)

Contact Information: ____________________________________________

(Phone Number) (E-mail Address)

Relationship to Applicant: ____________________________________________

% of Remaining Funds: ________________________________

If this remainderperson does not survive the beneficiary, what should happen to his/her share? (Check one.)

☐ Share to be distributed to other (living) primary remainderpersons listed on this form, in proportion to their respective beneficial interest.

☐ Distribute this share to this remainderperson’s descendants.

☐ Distribute this share to someone else:

Name: ____________________________________________

Address: ____________________________________________

__________________________

ULTIMATE REMAINDERPERSONS/ORGANIZATIONS

Please identify the individual(s) or entity that will receive any remaining funds not distributed as proved above. YOU MUST MAKE A SELECTION HERE.

☐ The individual or charity of my choice (Include an address):

Name: ____________________________________________

Address: ____________________________________________

Relationship to Applicant (if individual):

☐ My heirs at law.

REPORTING THE TRUST ACCOUNT

If the applicant receives SSI benefits and/or Medicaid, the establishment of this trust must be reported to the appropriate agencies. A PLAN attorney can submit that report, or in the alternative, provide supporting documentation to the applicant’s attorney for the report. The fee for either service is billed to the Trust Beneficiary’s account.

• Do you want the PLAN attorney to submit the report to the relevant agency? ☐ YES ☐ NO

Report to: ☐ Medicaid/MassHealth ☐ Social Security ☐ Housing Authority

• Do you want the PLAN attorney to submit supporting documentation to the applicant’s attorney? ☐ YES ☐ NO

Please note: If the applicant’s attorney submits the report, please forward a copy to PLAN.
SECTION VI: APPLICATION PREPARATION & SUBMISSION

APPLICATION PREPARATION

Who completed this application form?

Name: ________________________________

Address: ________________________________

Phone Numbers: ________________________________

(Home) (Cell) (Other-Please Specify)

E-Mail: ________________________________

Signature & Date: ________________________________

(Signature) (Date)

What is your relationship to the applicant?

☐ Applicant (Self)
☐ Applicant’s Guardian/Conservator
☐ Applicant’s Attorney-in-Fact (Power of Attorney)
☐ Applicant’s Attorney
☐ Other (Please Specify): ________________________________

How did the beneficiary hear about PLAN?

☐ Previous Experience with PLAN
☐ Attorney (Please Specify): ________________________________
☐ Family/Friend
☐ Community Organization: ________________________________
☐ Internet Search
☐ Brochure/Newsletter about PLAN
☐ Presentation/Workshop/Conference (Please Specify): ________________________________
☐ Other (Please Specify): ________________________________

Thank you for your interest in PLAN of Massachusetts and Rhode Island, Inc.

☐ By checking this box, the Applicant and/or the Representative acknowledges that they have read and understood all information requested by and responded to this Application, and all information contained in the MARC Information Guide.

_________________________________________ ______________________________________
(signature) (date)