

APPLICANT'S AGE & DISABILITY INFORMATION

Applicant's SSN, Age, Gender: _____ / _____ / _____ M F Other

Applicant's Disability: _____
 (Social Security #) (Date of Birth) (Gender)
 Developmental/Cognitive Mental Illness
 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

Health Coverage:	Medicaid/MassHealth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Applying
	Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Medicare Prescription Drug Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Private Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Income & Benefits:	Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Social Security Disability Income (SSDI)? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Social Security (Retirement)? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Wages? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Retirement Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Veterans Affairs Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	SNAP Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$
	Other? Specify: <input type="checkbox"/> Yes <input type="checkbox"/> No Amt/month: \$

NOTE: PLEASE PROVIDE PROOF OF ITEMS CHECKED YES

APPLICANT'S RESIDENTIAL & WORK/DAY SETTINGS

Type of Residence: Private Housing Nursing Home
 Group Home Assisted Living Facility
 Specialized Foster Care Other – Please Specify: _____

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

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: _____

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:

State:	Date(s) of Residence:

REAL PROPERTY

Does the applicant own any real property? YES NO If yes, please check the appropriate box:

- 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 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.

POA's
Name: _____

POA's
Address: _____
(Street) (City, State) (Zip Code)

POA's
Phone(s): _____
(Home) (Cell) (Other-Please Specify)

POA's E-Mail _____

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.

Conservator's
Name: _____

Conservator's
Address: _____
(Street) (City, State) (Zip Code)

Conservator's
Phone(s): _____
(Home) (Cell) (Other-Please Specify)

Conservator's E-
Mail(s): _____

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

FUNDING THE TRUST ACCOUNT

Initial Deposit to Trust: (Approx.) Inheritance Settlement Savings Other – Please Specify:

\$ _____
 (Amount) (Source of Funds)

Subsequent Deposit(s): (if applicable) \$ _____
 (Amount) (Source of Funds)

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?

Name:	Phone:	Email:	Relationship to Beneficiary:

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)

APPLICANT’S ATTORNEY

Attorney’s Name: _____

Attorney’s Address: _____
 (Street) (City, State) (Zip Code)

Attorney’s Phone(s): _____
 (Work) (Cell) (Other-Please Specify)

Attorney’s E-Mail: _____

Will this attorney be involved with the beneficiary on an ongoing basis? YES NO

SECTION V: REMAINDERPERSONS

PRIMARY REMAINDERPERSONS/ORGANIZATIONS

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%.**

Primary Remainderperson/Organization 1

Name: _____

Address: _____
(Street) (City, State) (Zip Code)

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:

Primary Remainderperson/Organization 2

Name: _____

Address: _____
(Street) (City, State) (Zip Code)

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:

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 you 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)