PLAN
Special Needs Trusts

MARC (First-Party) Special Needs Pooled Trust Application

(6/2022)

APPLICATION SUBMISSION

Please submit the completed application, W-9 and required attachments along with a check payable to PLAN of Massachusetts and Rhode Island, Inc. for the enrollment fee:

- **The fee is $600 for enrollments that do not involve a conservator, guardian, attorney-in-fact, or other fiduciary or agent.**
- **The fee is $750 for enrollments that do involve a conservator, guardian, attorney-in-fact, or other fiduciary or agent.**

Please see the Information Guide and/or Fee Schedule for a list of all fees.

PLAN will review the application and contact you if we require any additional information. Once approved, a PLAN attorney will draft an Instrument of Trust Assignment (ITA). This document will be forwarded to you along with instructions for establishing the account.

The enrollment process takes approximately 2 weeks from the date that we receive an application in good order. If you have any concerns regarding the time frame, please call us. Our primary goal is to provide you with the highest quality of service.

SECTION I: APPLICANT INFORMATION

APPLICANT'S CONTACT INFORMATION

Applicant's Name: _____
(Last) (Maiden, if applicable) (First) (Middle Initial)

Current physical address: _____
(Street) (City, State) (Zip Code)

Mailing address*: _____
(Street) (City, State) (Zip Code)

Current Phone Number(s): _____
(Home) (Cell) (Work)

E-Mail Address(es): _____

Applicant's Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Separated
☐ Widow/Widower ☐ Other (Please Specify): _____

Applicant's Children:
☐ Yes If yes, please list names and their ages:_____
☐ No _____
_____

*If the beneficiary resides in a nursing facility, please do not use the facility's address for mail, if possible.

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APPLICANT'S AGE & DISABILITY INFORMATION

Applicant's SSN, Age, Gender: ___ - ___ - ___ / ___ / ___ M ☐ F ☐ Other ☐

(Social Security Number) (Date of Birth) (Gender)

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: $	

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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:

State:	Date(s) of Residence:

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: _____
_____

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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)

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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.

<u>Please note:</u> 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, <u>and</u> 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): _____

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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): _____

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SECTION III: FUNDING & DISBURSEMENTS

FUNDING THE TRUST ACCOUNT

Initial Deposit to Trust: (Approx.)

☐ Inheritance ☐ Settlement
☐ Savings ☐ Other – Please Specify:

$ _____
(Amount) (Source of Funds)

Note: If under $10,000, contact PLAN

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

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

Primary Remainderperson/Organization 1

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:

Primary Remainderperson/Organization 2

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:

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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 <u>one</u>.)**

☐ 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. **<u>YOU MUST MAKE A SELECTION HERE</u>.**

☐ 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

- 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.

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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)