PLAN
Special Needs Trusts

APPLICANT'S AGE & DISABILITY INFORMATION

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

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

Applicant's Disability:
☐ Developmental/ Cognitive
☐ Physical
☐ Mental Illness
☐ 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?	☐ 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: $
	Other? Specify:	☐ Yes	☐ No	Amt/month: $

NOTE: PLEASE PROVIDE PROOF OF ITEMS CHECKED YES

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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%.**

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:

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Primary Remainderperson/Organization 3

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:

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

- 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 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)