



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 No If yes, please list names and their ages: _____

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

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 : 9.28.2022



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 Physical Neurological

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?	<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: \$
	Annuity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$
	Long Term Care Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$
	Other? Specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$



APPLICANT'S RESIDENTIAL & WORK/DAY SETTINGS

In what setting does the beneficiary primarily reside? 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: _____

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: _____

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.

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%.**

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:



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
- 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.



Special Needs Trusts

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)