PLAN
Special Needs Trusts

PLAN of MA & RI Third Party Trust Application

☐ Funded at Time of Signing ☐ Future Funded (09/2022)

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 of $500**.

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.

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: DONOR INFORMATION

DONOR'S CONTACT INFORMATION

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

Donor's Social Security Number: ___ - ___ - _____

Residential address: _____
(Street) (City, State) (Zip Code)

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

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

E-Mail Address: _____

Relationship to Beneficiary: _____

☐ If there is more than one donor, please check this box and complete the Additional Donor Contact Information page at the end of the application.

SECTION II: BENEFICIARY INFORMATION

BENEFICIARY INFORMATION

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

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

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

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

Email Address(es): _____

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Beneficiary's SSN, Date of Birth, Gender: - - / / M ☐ F ☐ Other ☐

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

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

Name of Spouse or Partner (if any): _____

Beneficiary's Children:
☐ Yes
☐ No _____
_____
_____

Beneficiary's Disability:
☐ Developmental/ Cognitive ☐ Mental Illness ☐ Physical
☐ Neurological
☐ Other (Please Specify): _____

How does the Beneficiary's disability affect his or her life? (Is he or she unable to work, unable to live independently, etc?): _____

_____

If the Beneficiary's condition has been diagnosed, what is the diagnosis?

_____

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 beneficiary applying to SSA for a disability determination? ☐ Yes ☐ No ☐ Not Certain

BENEFICIARY'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

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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: $

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

- 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

BENEFICIARY'S RESIDENTIAL & WORK/DAY SETTINGS

Type of Residence:

☐ 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/Agency: _____
(Name)

_____
(Address)

Day Program Provider: _____

If the beneficiary 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 beneficiary receive a housing subsidy of any kind? ☐ YES ☐ NO
If YES, what type and how much money is received per month? _____

_____

Is the beneficiary currently on a waiting list for a housing subsidy? ☐ YES ☐ NO

Is the beneficiary receiving community supports?
DDS ☐ YES ☐ NO
DMH ☐ YES ☐ NO
Private Case Management ☐ YES ☐ NO

Is the beneficiary involved in any programs? ☐ YES ☐ NO

_____

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BENEFICIARY'S END-OF-LIFE ARRANGEMENTS

Does the beneficiary have a pre-paid funeral/burial contract? ☐ YES ☐ NO

Does the beneficiary have a Will? ☐ YES **(If so, please submit copy)** ☐ NO

Does the Beneficiary have the right to live in any property that is held in trust? ☐ YES ☐ NO

If yes, please provide a copy of the trust and deed.

If yes, address of property in trust:_____

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

- 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

SECTION III: DONOR SIGNOR AND REPRESENTATIVE INFORMATION

SIGNOR INFORMATION

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

☐ Donor ☐ Donor's Trustee ☐ Donor's Conservator/Guardian ☐ Donor's POA

If someone will be signing on behalf of the Donor, please provide the authorizing document (power of attorney, conservatorship decree, trust document).

SECTION IV: BENEFICIARY REPRESENTATIVE INFORMATION

POWER OF ATTORNEY INFORMATION

If the beneficiary has a Power of Attorney/Attorney-in-Fact, whether or not the Power of Attorney is currently acting on behalf of the beneficiary, 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 _____

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CONSERVATOR INFORMATION

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

Please submit any Decree of Guardianship or Conservatorship with the application.

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 beneficiary 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): _____

REPRESENTATIVE PAYEE

If the beneficiary 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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CAREGIVER OR ADVOCATE

Is there anyone else involved in managing the beneficiary's care?

Caregiver(s) Name: _____

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

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

Caregiver(s) E-Mail(s): _____

SECTION IV: FUNDING & DISBURSEMENTS

FUNDING THE TRUST ACCOUNT

If future funded, what event will trigger funding? (e.g. death of donor, termination of existing trust, etc.)

Funding event: _____

Initial Deposit to Trust: (Approx.)

Note: If under $10,000, contact PLAN

☐ Inheritance ☐ Insurance
☐ IRA ☐ VA
☐ Pension ☐ Other – Please Specify:

$ _____
(Amount) (Source of Funds)

Are other deposits anticipated?

☐ YES ☐ NO

$ _____
(Amount) (Source of Funds)

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**.

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SECTION VI: ATTORNEY INFORMATION (if applicable)

DONOR'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 donor on an ongoing basis? ☐ YES ☐ NO

BENEFICIARY'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 VII: REMAINDERPERSONS

TRUST'S REMAINDER SHARE

If you elect for some percentage of the beneficiary's Sub-Account Remainder to be retained by the trust after the beneficiary's death, such funds will be used in the trustee's discretion as follows:

1. **For the benefit of other indigent beneficiaries;**
2. **To add indigent disabled persons to the trust, as defined in the Social Security Act;**
3. **To provide indigent disabled persons, as defined in the Social Security Act, with equipment, medication or services deemed suitable for such persons by the trustee;**
4. **To pay for ongoing administrative expenses of the trust; and**
5. **To pay for other expenses that promote the charitable purposes of PLAN of Massachusetts and Rhode Island, Inc.**

Percentage to be retained by trust after beneficiary's death:

☐ 50% ☐ 25% ☐ Other _____

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EARLY TERMINATION

Article XIV of the trust provides that under certain circumstances a Sub-Account (or the entire trust) may be terminated prior to the beneficiary's death. If the beneficiary's Sub-Account is terminated before his or her death, the trustee will either distribute the Sub-Account's funds to the beneficiary or on behalf of the beneficiary unless the trustee, in its sole discretion, deems such distribution not to be in the beneficiary's best interest, how should the funds be distributed upon early termination of the beneficiary's Sub-Account?

☐ To the Donor (if then-living)

☐ To the Primary Remainderpersons/Organizations listed below.

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 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: TELEPHONE

ADDRESS:

CURRENT AGE: PERCENTAGE OF FINAL REMAINDER:

EMAIL: RELATIONSHIP TO DONOR:

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

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

☐ Distribute this share to this remainder person's descendants.

☐ Distribute this share to someone else:

Name:	Address:

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Primary Remainderperson/Organization 2

NAME: TELEPHONE

ADDRESS:

CURRENT AGE: PERCENTAGE OF FINAL REMAINDER:

EMAIL: RELATIONSHIP TO DONOR:

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

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

☐ Distribute this share to this remainder person's descendants.

☐ Distribute this share to someone else:

Name:	Address:

Primary Remainderperson/Organization 3

NAME: TELEPHONE

ADDRESS:

CURRENT AGE: PERCENTAGE OF FINAL REMAINDER:

EMAIL: RELATIONSHIP TO DONOR:

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

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

☐ Distribute this share to this remainder person's descendants.

☐ Distribute this share to someone else:

Name:	Address:

☐ **If there are additional remainderpersons, please check this box and complete the Additional Primary Remainderperson page at the end of the application.**

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SECTION VII: 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 beneficiary?
☐ Beneficiary's Parent
☐ Beneficiary's Guardian/Conservator
☐ Beneficiary's Attorney-in-Fact (Power of Attorney)
☐ Beneficiary's Attorney
☐ Other (Please Specify): _____

How did the donor hear about PLAN?
☐ Previous Experience with PLAN
☐ Attorney (Please Specify): _____
☐ Family/Friend
☐ Community Organization (Please Specify): _____
☐ 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 Donor 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 Third Party Information Guide.

_____ _____
(signature) (date)

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ADDITIONAL DONOR'S CONTACT INFORMATION

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

Donor's Social Security Number: ___ - ___ - _____

Residential address: _____
(Street) (City, State) (Zip Code)

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

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

E-Mail Address: _____

Relationship to Beneficiary: _____

ADDITIONAL DONOR'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 donor on an ongoing basis? ☐ YES ☐ NO

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ADDITIONAL PRIMARY REMAINDERPERSONS/ORGANIZATIONS

Primary Remainderperson/Organization # ___

NAME: TELEPHONE

ADDRESS:

CURRENT AGE: PERCENTAGE OF FINAL REMAINDER:

EMAIL: RELATIONSHIP TO DONOR:

If this remainder person does not survive the beneficiary, what should happen to his/her share? (**Check <u>one.</u>**)

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

☐ Distribute this share to this remainder person's descendants.

☐ Distribute this share to someone else:

Name:	Address: