PLAN
Special Needs Trusts

FIRST-PARTY SPECIAL NEEDS TRUST APPLICATION

Trust Type (Select One): ☐ MARC Pooled ☐ Standalone (d4A)
$750,000 Minimum

APPLICATION SUBMISSION

To begin the enrollment process, submit the complete application, a W-9, and all other required supporting documents (outlined on the last page of the application) to PLAN by post mail, electronically (on our website or by email), or facsimile (fax).

There is a **non-refundable enrollment fee** of:

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

Please pay by check made payable to PLAN of MA & RI, Inc.

For a list of all fees, see the First-Party Trust Information Guide.

SECTION I: BENEFICIARY INFORMATION

The "beneficiary" is the applicant. If you are completing the application on behalf of someone else, your information will be collected on a later page.

BENEFICIARY'S CONTACT INFORMATION

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

Beneficiary Identification: _____ _____
(Social Security Number) (Date of Birth)

Beneficiary's Physical Address: _____
(Street) (City, State) (ZIP Code)

Beneficiary's Phone Number(s): _____
(Home) (Cell) (Other, Please Specify)

Beneficiary's Email Address: _____

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

Does the beneficiary have children? ☐ Yes ☐ No If yes, please list their names and ages: _____

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BENEFICIARY'S DISABILITY INFORMATION

Type of Disability: ☐ Neurological ☐ Developmental/Cognitive ☐ Mental Illness ☐ Physical ☐ Other (Please Specify): _____

Medical Diagnoses: _____

_____

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

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	
	Other? Specify:	☐ 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: $
	Pension?	☐ Yes	☐ No	Amt/month: $
	Other? Specify:	☐ Yes	☐ No	Amt/month: $

OPTIONAL DEMOGRAPHICS

Gender: ☐ M ☐ F ☐ Other **Preferred Language:** _____

Race: ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Black/African American ☐ Native American or Alaska Native ☐ Other: _____

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BENEFICIARY'S RESIDENTIAL AND WORK/DAY SETTINGS

In what type of setting does the beneficiary primarily reside?

☐ Private Housing
☐ Group Home
☐ Specialize Foster Care
☐ Nursing Home
☐ Assisted Living Facility
☐ Other (Please Specify): _____

Residential Provider:

_____ _____
(Name) (Address)

Work/Day Setting:

☐ Employment Full Time
☐ Employment Past Time
☐ None
☐ Day Program
☐ Other (Please Specify): _____

Day Program Provider:

_____ _____
(Name) (Address)

If the beneficiary is living in an institutional setting, are they expected to return to a community-based setting? ☐ Yes ☐ No If yes, provide anticipated date: _____

If YES, please provide a copy of the short-term approval letter.

Does the beneficiary receive a housing subsidy of any kind? ☐ Yes ☐ No

If yes, what type of subsidy and how much money is received per month?

_____

_____

Is the beneficiary currently on a waitlist for a housing subsidy? ☐ Yes ☐ No

Has the beneficiary ever lived in another state? ☐ Yes ☐ No

If yes, please list the state(s) and date(s) of residence:

State:	Date(s) of Residence:

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REAL PROPERTY

Does the beneficiary 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 beneficiary
□ The property is being used for rental income
□ The property is vacant pending sale
□ Other (please explain): _____

_____

Please provide the address of the property:

_____

LIFE ESTATE INFORMATION

Does the beneficiary have a life estate in any real property? ☐ Yes ☐ No

If yes, please provide the address of the property:

_____

BENEFICIARY'S END-OF-LIFE ARRANGEMENTS

Does the beneficiary have a pre-paid funeral/burial contract?
☐ Yes (If yes, please submit a copy) ☐ No

Does the beneficiary have a Will?
☐ Yes (If yes, please submit a copy) ☐ No

(Please continue application on the next page)

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SECTION II: SIGNOR AND REPRESENTATIVE INFORMATION

SIGNOR INFORMATION

Who will be signing the trust documents? (**Please select <u>one</u>**.)

☐ Beneficiary ☐ Beneficiary's Power of Attorney ☐ Beneficiary's Conservator

Please note: A conservator can only create an irrevocable trust if he or she has explicit authority from the court to do so. If the CONSERVATOR will be signing the trust documents on behalf of the beneficiary, please submit the following with this application: Decree of Conservatorship and/or Court Order allowing a Petition to Expand or allowing a Petition for a Single Transaction.

POWER OF ATTORNEY (POA) INFORMATION

If the beneficiary has a Power of Attorney/Attorney-in-Fact, whether or not the beneficiary 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: _____
(Last) (Maiden, if applicable) (First) (Middle Initial)

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

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

POA's Email Address: _____

CONSERVATORSHIP INFORMATION

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

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

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

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

Conservator's Email Address: _____

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GUARDIANSHIP INFORMATION

If the beneficiary has a guardian, please complete this section.

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

Guardian's Address: _____
(Street) (City, State) (ZIP Code)

Guardian's Phone Number(s): _____
(Home) (Cell) (Other, Please Specify)

Guardian's Email Address: _____

REPRESENTATIVE PAYEE INFORMATION

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 perceived to be incapable of managing their own benefits.

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

Rep Payee's Address: _____
(Street) (City, State) (ZIP Code)

Rep Payee's Phone Number(s): _____
(Home) (Cell) (Other, Please Specify)

Rep Payee's Email Address: _____

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SECTION III: TRUST OPERATIONS

FUNDING THE TRUST ACCOUNT

Initial Deposit to Trust:
(Approximate)

☐ Inheritance ☐ Settlement
☐ Savings ☐ Other
(Please Specify):

$ _____ _____

Note: If under $10,000, contact PLAN

(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.

TRUST COMMUNICATIONS

Where should mailings about the trust, including bank statements and tax documents, be sent?
In most cases, this address should match the address provided on the W-9.

Recipient's Name: _____

(Last) (First) (Middle Initial)

Mailing Address: _____

(Street) (City, State) (ZIP Code)

Email Address: _____

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, also known as disbursements. Who should be contacted for this purpose?

☐ Check this box if the Disbursement Contact is the same as the person listed to receive Trust Communications.

Name: _____ Phone: _____

Relationship to Beneficiary: _____ Email: _____

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SECTION IV: ATTORNEY INFORMATION (IF APPLICABLE)

BENEFICIARY'S ATTORNEY

Attorney's Name: _____

Attorney's Address: _____
(Street) (City, State) (ZIP Code)

Attorney's Phone Number(s): _____
(Work) (Cell) (Other, Please Specify)

Attorney's Email Address: _____

Will this attorney be involved with the donor on an ongoing basis? ☐ Yes ☐ No

REPORTING THE TRUST ACCOUNT

If the beneficiary 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 beneficiary's attorney for the report. The fee for either service is billed to the Trust Beneficiary's account.

Do you want a PLAN attorney to submit the report to the relevant agency?

☐ Yes ☐ No

If yes, report to:

☐ Medicaid/MassHealth ☐ Social Security ☐ Housing Authority

Do you want a PLAN attorney to submit supporting documentation to the beneficiary's attorney?

☐ Yes ☐ No

Note: If the beneficiary's attorney submits the report, please forward a copy to PLAN.

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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 remainder to PLAN (10% for a beneficiary who dies within two (2) years of joining the trust or 20% for a beneficiary who dies more than two (2) years after joining the trust), 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 any change in address or contact information for the remainderpersons that occur during the time the trust is active.

Primary Remainderperson/Organization 1

Name: _____
(Last) (First) (Middle Initial)

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

Contact Information: _____
(Phone Number) (Email Address)

Relationship to Beneficiary: _____

% of Remaining Funds: _____

If this remainderperson (#1) does not survive the beneficiary, what should happen to their 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: _____
(Last) (First) (Middle Initial)

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

Contact Information: _____

(Phone Number) (Email Address)

Relationship to Beneficiary: _____

% of Remaining Funds: _____

If this remainderperson (#2) does not survive the beneficiary, what should happen to their 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: _____

(Last) (First) (Middle Initial)

Address: _____

(Street) (City, State) (ZIP Code)

Contact Information: _____

(Phone Number) (Email Address)

Relationship to Beneficiary: _____

% of Remaining Funds: _____

If this remainderperson (#3) does not survive the beneficiary, what should happen to their 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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ULTIMATE REMAINDER ORGANIZATION

Please identify the entity that will receive any remaining funds not distributed as provided above. **YOU MUST MAKE A SELECTION HERE.**

☐ PLAN of Massachusetts and Rhode Island, Inc.

If you elect for 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 beneficiaries in need;
2. To add disabled persons in need to the trust, as defined in the Social Security Act;
3. To provide disabled persons in need, 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.

☐ The following charity

Name:
Address:

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SECTION VI: APPLICATION PREPARATION

APPLICATION PREPARATION

Who completed this application form?

Name: _____

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

Phone Number(s): _____
(Home) (Cell) (Other, Please Specify)

Email Address: _____

Signature: _____
(Signature) (Date)

What is your relationship to the beneficiary?

☐ Beneficiary (Self)
☐ Beneficiary's Guardian/Conservator
☐ Beneficiary's Attorney-in-Fact (Power of Attorney)
☐ Beneficiary'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, or 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 or their Representative acknowledges that they have read and understood all information requested by and responded to this Application, and all information contained in the First Party Information Guide.

Signature: _____
(Signature) (Date)

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APPLICATION CHECKLIST & NEXT STEPS

To begin the enrollment process, please check off what applicable documents are included and provide to PLAN by post mail, electronically (on our website or by email), or facsimile (fax).

FOR ALL APPLICANTS

☐ Application – Completed and Signed

☐ W-9 for beneficiary, signed and dated (electronic or wet signature accepted)

☐ Check for Enrollment Fee made payable to PLAN of MA & RI*
**The enrollment fee can only be submitted by mail and is non-refundable.*

☐ Copy of most recent bank statement or Income Statement from SSA

☐ Copy of health insurance card(s)

☐ Supporting documents for all health coverage, benefits, and income marked YES (page 2)

IF APPLICABLE

☐ Short-term approval letter for return to community-based living (page 3)

☐ Deed for real property (page 4)

☐ Copy of life estate (page 4)

☐ Pre-paid Funeral (page 4)

☐ Will (page 4)

☐ Power of Attorney (page 5)

☐ Decree of Conservatorship (page 5)

☐ Appointment of Guardianship (page 6)

☐ Evidence of satisfied lien (page 7)

☐ Other: _____

AFTER SUBMISSION

The person who completed the application (as indicated on page 13) will get a confirmation email when the application has been received by PLAN's Enrollment team.
We will review your application and contact you if any further information is required.

From the time your application is confirmed to be in good order, the enrollment process takes approximately 2 weeks. If you have any concerns regarding the time frame, please contact us at 617-244-5552 or email enrollment@planofma-ri.org.

Our primary goal is to provide you with the highest quality of service.