





Special Needs Trusts

**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.

<b>Health Coverage:</b>	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	
	Other? Specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Income &amp; Benefits:</b>	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: \$
	Pension?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$
	Other? Specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: \_\_\_\_\_

**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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**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):

\$ \_\_\_\_\_  
 (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.

#### 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: \_\_\_\_\_

**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 beneficiary 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:

<b>Name:</b>	<b>Address:</b>

#### Primary Remainderperson/Organization 2

**Name:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

**Address:** \_\_\_\_\_  
(Street) (City, State) (ZIP Code)



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**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:

**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

<b>Name:</b>
<b>Address:</b>



## 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)

## 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](mailto:enrollment@planofma-ri.org).

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