PLAN
Special Needs Trusts

THIRD-PARTY SPECIAL NEEDS TRUST APPLICATION

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

Funding Type (Select One): ☐ Funded at Signing ☐ Future Funded

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 $500, which can be paid by check made payable to PLAN of MA & RI, Inc.

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

SECTION I: DONOR INFORMATION

DONOR'S INFORMATION

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

Donor's Identification: ___ - ___ - ____ / ___ / ____
(Social Security Number) (Date of Birth)

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

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

Donor's Email Address: _____

Relationship to Beneficiary: _____

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

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SECTION II: BENEFICIARY INFORMATION

BENEFICIARY 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): _____

Name of Partner (if applicable): _____

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

DISABILITY INFORMATION

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

How does the Beneficiary's disability affect their life? (Are they unable to work, unable to live independently, etc.?) _____

If the Beneficiary's condition(s) 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 applicant applying to SSA for a disability determination? ☐ Yes ☐ No ☐ Not Certain

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

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RESIDENTIAL AND WORK/DAY SETTINGS

In what type of setting does the beneficiary primarily reside?

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

Residential Provider: _____
(Name) (Address)

Work/Day Setting:

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

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: _____

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, as well as the address of the property:

_____

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 on a waitlist for a housing subsidy? ☐ Yes ☐ No

Is the beneficiary receiving the following community support?

Department of Developmental Services (DDS) ☐ Yes ☐ No
Department of Mental Health (DMH) ☐ Yes ☐ No
Private Case Management ☐ Yes ☐ No
Is the beneficiary involved in any programs? ☐ Yes ☐ No
If yes, please list: _____

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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 for rental income
☐ The property is vacant pending sale
☐ Other (please explain): _____

_____

Please provide the address of the property:

_____

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:

_____

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

SECTION III: SIGNOR AND REPRESENTATIVE INFORMATION

SIGNOR INFORMATION

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

☐ Donor
☐ Donor's Conservator*
☐ Donor's Power of Attorney
☐ Donor's Trustee

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

***A conservator can only create an irrevocable trust if they have explicit authority from the court to do so. If the CONSERVATOR will be signing the trust documents on behalf of the donor, 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.**

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SECTION IV: REPRESENTATIVE INFORMATION

POWER OF ATTORNEY (POA) 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.

POA's Name: _____
(Last) (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 applicant has a court-appointed conservator, please complete this section.

Conservator's Name: _____
(Last) (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: _____

GUARDIANSHIP INFORMATION

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

Guardian's Name: _____
(Last) (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: _____

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REPRESENTATIVE PAYEE INFORMATION

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 SSA 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) (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: _____

CAREGIVER OR ADVOCATE INFORMATION

For anyone else involved in managing the beneficiary's care, please complete this section.

Name: _____
(Last) (First) (Middle Initial) (Relationship to Beneficiary)

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

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

Email Address: _____

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SECTION V: TRUST OPERATIONS

FUNDING THE TRUST ACCOUNT

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

Initial Deposit to Trust: (Approximate)

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

Note: If under $10,000, contact PLAN

$ _____
(Amount) (Source of Funds)

Are other deposits anticipated?

☐ Yes ☐ No

$ _____
(Amount) (Source of Funds)

TRUST COMMUNICATIONS

Where should mailings about the trust, including bank statements and tax documents, be sent?
If this is a future-funded trust that will be funded upon the death of the donor, please consider who should receive these documents once the trust has been funded.

Recipient's Name: _____
(Last) (First) (Middle Initial)

Physical 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?
If this is a future-funded trust that will be funded upon the death of the donor, please consider who would be an appropriate point of contact once the trust has been funded.

☐ 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 VI: ATTORNEY INFORMATION (IF APPLICABLE)

DONOR'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

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

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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 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.

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

☐ 50% ☐ 25% ☐ Other (please specify): _____

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 their 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 is not 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

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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 any change in address or contact information for the remainderpersons that occur prior to or 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 Applicant: _____

% 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 Applicant: _____

% 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 Applicant: _____

% 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 VIII: 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'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: _____
☐ 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 Donor (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 Third-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 them 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 Donor, signed and dated (electronic or wet signature accepted)

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

☐ Check for Enrollment Fee ($500) 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 3)

IF APPLICABLE

☐ Deed for real property (page 4)

☐ Copy of life estate (page 4)

☐ Pre-paid Funeral (page 5)

☐ Will (page 5)

☐ Power of Attorney (page 5)

☐ Decree of Conservatorship (page 6)

☐ Appointment of Guardianship (page 6)

☐ Other: _____

AFTER SUBMISSION

The person who completed the application (as indicated on page 15) 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.

ADD ON: ADDITIONAL DONOR

ADDITIONAL DONOR'S INFORMATION

Donor's Name: _____

(Last) (Maiden, if applicable) (First) (Middle Initial)

Donor Identification: ___ - ___ - ____ / ___ / ____

(Social Security Number) (Date of Birth)

Donor's Residential Address: _____

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

Donor's Phone Number(s): _____

(Home) (Cell) (Other, Please

Donor's Email Address: _____

Relationship to Beneficiary:

ADDITIONAL DONOR'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

ADD ON: ADDITIONAL REMAIDERPERSONS

Primary Remainderperson/Organization #___

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

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

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

Relationship to Applicant: _____

% of Remaining Funds: _____

If this remainderperson (#___) 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: