



Special Needs Trusts

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

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?	<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	

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: \$
	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
 Black/African American Native American or Alaska Native
 White Other: _____



RESIDENTIAL AND WORK/DAY SETTINGS

In what type of setting does the beneficiary primarily reside?

- Private Housing
- Group Home
- Specialized 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: _____

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: _____

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.**

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: _____

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

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

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)

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 REMAINDERPERSONS

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: