

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## MARC Special Needs Pooled Trust Application

(10/2013)

### APPLICATION SUBMISSION

Please submit the completed application and required attachments along with a check payable to PLAN of Massachusetts and Rhode Island for the enrollment fee:

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

Please see the Informational Packet and/or Fee Schedule for a list of all fees.

PLAN of Massachusetts and Rhode Island will review the application and contact you if we require any additional information. Once approved, a PLAN attorney will draft an Instrument of Trust Assignment. This document will be forwarded to you along with instructions for establishing the account.

Thank you for your interest in PLAN of Massachusetts and Rhode Island.

### SECTION I: APPLICANT INFORMATION

#### APPLICANT'S CONTACT INFORMATION

Applicant's Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Current Residence: \_\_\_\_\_  
(Street) (City, State) (Zip Code)

Mailing Address: \_\_\_\_\_  
(Street) (City, State) (Zip Code)

Current Phone Number(s): \_\_\_\_\_  
(Home) (Cell) (Other-Please Specify)

E-Mail Address(es): \_\_\_\_\_

Applicant's Marital Status:  Single  Married  Divorced  Separated  Widow/Widower  Other (Please Specify): \_\_\_\_\_

Applicant's Children:  Yes  No If yes, please list how many and their ages:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## APPLICANT'S RESIDENTIAL & WORK/DAY SETTINGS

Type of Residence:  Private Housing  Nursing Home  
 Group Home  Assisted Living Facility  
 Specialized Foster Care  Other – Please Specify: \_\_\_\_\_

Work/Day Setting:  Employment – full-time  Day Program  
 Employment – part-time  Other – Please Specify: \_\_\_\_\_  
 None

Providers (if applicable): Residential Provider: \_\_\_\_\_  
Day Program Provider: \_\_\_\_\_

If the applicant 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 applicant receive a housing subsidy of any kind?  YES  NO  
If YES, what type and how much money is received per month? \_\_\_\_\_

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

Has the applicant ever lived in another state?  YES  NO

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

State:	Date(s) of Residence:

## APPLICANT'S AGE & DISABILITY INFORMATION

Applicant's SSN & Age: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Social Security #) (Date of Birth)

Applicant's Disability:  Developmental Disability  Mental Illness  
 Physical Disability  Other (Please Specify): \_\_\_\_\_

Applicant's 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

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## APPLICANT'S BENEFITS INFORMATION

Health Coverage:	Medicaid/MassHealth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	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	
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: \$
	Pension?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$
	Annuity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$
	Other? Specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amt/month: \$

## APPLICANT'S END-OF-LIFE ARRANGEMENTS

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

Does the applicant have a Will?  YES       NO

## REAL PROPERTY

Does the applicant own any real property?  YES     NO    If yes, please check the appropriate box:

The property is currently occupied by someone other than the applicant

The property is being used as rental income

The property is vacant pending its 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: \_\_\_\_\_

\_\_\_\_\_

Is someone other than the beneficiary living at the property?     YES       NO       N/A

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## SECTION II: SIGNOR AND REPRESENTATIVE INFORMATION

### SIGNOR INFORMATION

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

Beneficiary       Beneficiary's Guardian/Conservator       Beneficiary's Power of Attorney

### GUARDIAN/CONSERVATOR INFORMATION

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

**Please Note:** If the GUARDIAN or CONSERVATOR will be signing trust documents on behalf of the beneficiary, please submit the following with this application: Decree of Guardianship/Conservatorship, Petition to Establish an Estate Plan, and the Court Order approving the petition.

Guardian's/Conservator's  
Name:

\_\_\_\_\_

Guardian's/  
Conservator's Address:

\_\_\_\_\_ (Street) \_\_\_\_\_ (City, State) \_\_\_\_\_ (Zip Code)

Guardian's/Conservator's  
Phone(s):

\_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Other-Please Specify)

Guardian's/Conservator's  
E-Mail(s):

\_\_\_\_\_

### POWER OF ATTORNEY INFORMATION

If the applicant has a Power of Attorney/Attorney-in-Fact, 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

\_\_\_\_\_

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## REPRESENTATIVE PAYEE

If the applicant has a representative payee, please complete this section.

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): \_\_\_\_\_

### SECTION III: FUNDING & DISBURSEMENTS

#### FUNDING THE TRUST ACCOUNT

Initial Deposit to Trust:  Inheritance  Settlement  
 Savings  Other – Please Specify:

\$ \_\_\_\_\_  
(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, please submit evidence with the application demonstrating that the lien has been satisfied.

#### 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 of Massachusetts and Rhode Island, Trustee, has total and sole discretion in making payments from an individual's MARC Special Needs Pooled Trust account. **All payments must be for the sole benefit of the trust beneficiary.**

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## SECTION IV: ATTORNEY INFORMATION

### APPLICANT'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 V: REMAINDERPERSONS

### PRIMARY REMAINDERPERSONS/ORGANIZATIONS

Please 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 10% (Trust Beneficiary dies within two (2) years of joining the trust) or 20% (Trust Beneficiary dies more than two (2) years after joining the trust) remainder to PLAN of Massachusetts and Rhode Island, and after all Medicaid claims have been paid or settled. Please specify what percentage of the remaining funds you wish each to receive. Percentages must total 100%.

*Primary Remainderperson/Organization 1*

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City, State) (Zip Code)

Relationship to Applicant: \_\_\_\_\_

% of Remaining Funds: \_\_\_\_\_

If this remainderperson does not survive the beneficiary, what should happen to his/her share? (Please 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:

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

**Primary Remainderperson/Organization 2**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City, State) (Zip Code)

Relationship to Applicant: \_\_\_\_\_

% of Remaining Funds: \_\_\_\_\_

If this remainderperson does not survive the beneficiary, what should happen to his/her share?  
 (Please 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: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City, State) (Zip Code)

Relationship to Applicant: \_\_\_\_\_

% of Remaining Funds: \_\_\_\_\_

If this remainderperson does not survive the beneficiary, what should happen to his/her share?  
 (Please 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:

# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## ULTIMATE REMAINDER PERSONS/ORGANIZATIONS

Please identify the individual(s) or entity that will receive any remaining funds not distributed as proved above. **You must make a selection here.**

The individual or charity of my choice (Include an address):

Name:	Address:
Relationship to Applicant (if individual):	

My heirs at law.

## REPORTING THE TRUST ACCOUNT

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

- Do you want the PLAN attorney to submit the report to the relevant agency?  YES  NO
- Do you want the PLAN attorney to submit supporting documentation to the applicant's attorney?  YES  NO

If the applicant's attorney submits the report, please forward a copy to PLAN of Massachusetts and Rhode Island.



# PLAN of Massachusetts and Rhode Island

*Planned Lifetime Assistance Network of Massachusetts and Rhode Island, Inc.*

## SECTION VI: 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 applicant?

- Applicant (Self)
- Applicant's Guardian/Conservator
- Applicant's Attorney-in-Fact (Power of Attorney)
- Applicant's Attorney
- Other (Please Indicate): \_\_\_\_\_

**Thank you for your interest in PLAN of Massachusetts and Rhode Island.**