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: _____

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APPLICANT'S RESIDENTIAL & WORK/DAY SETTINGS

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

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

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
☐ Physical Disability
☐ Mental Illness
☐ 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

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APPLICANT'S BENEFITS INFORMATION

Health Coverage:	Medicaid/MassHealth?	☐ Yes	☐ No	
	Medicare?	☐ Yes	☐ No	
	Medicare Prescription Drug Coverage?	☐ Yes	☐ No	
	Private Health Insurance?	☐ Yes	☐ No	
	Dental Insurance?	☐ 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: $
	Pension?	☐ Yes	☐ No	Amt/month: $
	Annuity?	☐ Yes	☐ No	Amt/month: $
	Other? Specify:	☐ Yes	☐ 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

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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 _____

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**.

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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:

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:

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ULTIMATE REMAINDERPERSONS/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.

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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 Specify): _____

How did you hear about PLAN?
☐ Previous Experience with PLAN
☐ Attorney (Please Specify): _____
☐ Family/Friend
☐ Community Organization
☐ Internet Search
☐ Brochure/Newsletter about PLAN
☐ Presentation/Workshop/Conference (Please Specify): _____
☐ Other (Please Specify): _____

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

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