Beneficiary Background Information

Date completed: _____
Full Name of beneficiary: _____
Beneficiary prefers to be called: _____

Birth date_____**Birthplace**_____
City, State, Country if not U.S.A.

Social Security Number: _____

Beneficiary Contact Information		
Check if applicable: □ **Do NOT communicate directly with beneficiary**		
Address:		
City:	State:	Zip:
Telephone: (Home) (Mobile)		
Email		

Please describe your disability and its impact on your life in your own words:

_____
_____
_____

Does your disability have a medical diagnosis? If so, can you tell us what it is and how you think it will impact your future? _____
_____
_____
_____

What is important to you in your life that you hope these funds will help you maintain or accomplish? _____

_____

_____

What is important for you in your life to stay healthy and safe that you hope these funds will support or provide? _____

_____

_____

1. Is this trust established by court order? YES □ NO □

**include a copy of court order.*

2. What is the source of funds for the trust?

□ **Funds of the third party settlor** (not beneficiary).

**Family gift, inheritance paying directly to trust, life insurance directly to trust.*

□ **Funds of the beneficiary** - From a personal injury settlement. **include a copy of this settlement, including but not limited to annuity schedule and future deposit amounts expected with dates.*

□ **Funds of the beneficiary** - Inheritance.

**Include a copy of Last Will and Testament of the deceased.*

□ **Funds of the beneficiary** - Social Security back pay or retroactive payment.

□ **Funds of the beneficiary** - Conserved funds, life insurance payout or other fund.

3. What is the beneficiary's disability?

□ Developmental disability

□ Mental illness

□ Brain injury/spinal cord Injury

□ Physical disability - specify_____

4. Date of Social Security Administration Disability Determination_____

5. What is the beneficiary's current living arrangement?

□ Lives alone

□ Lives with family

List names, relationship, and age of others in household

_____

_____

_____

□ Lives in a care facility

□ Staffed Residence

□ Group Home

□ ICF (Intermediate Care Facility)

□ RCF (Residential Care Facility)
□ SNF (Skilled Nursing Facility - Nursing Home)
□ Other State operated facility - Specify_____
□ Other - Specify_____

6. If applicable, please enter address of facility where the beneficiary resides:

Facility Name:		
Address:		
City:	State:	Zip:
Telephone:	Fax:	
Staff Contact Name:		
Email:		

7. List the key agencies that provide service to the beneficiary:

**** Examples of agencies include, but are not limited to, home health care, transportation, vocational, or case management services, Not necessary to list Social security or Medicaid in this section.***

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

8. What sources of income does the beneficiary currently receive?

Include a copy of the first award letter and/or the most recent Social Security Administration letter.

Income	**Monthly Amount**
Supplemental Security Income (**SSI**) Date check or deposit is issued monthly:	
Social Security Disability Income (**SSDI**) Date check or deposit is issued monthly: _____ Based on Beneficiary's work record or parent's? _____	
Social Security Retirement Income **(RSDI)**[1] Date check or deposit is issued monthly: _____ Based on Beneficiary's work record or parent's? _____	
Employment (Include 2 pay stubs)	
Veterans Administration Aid and Attendance Benefits	
Other - Specify[1]	
Total Cash Income	

9. What other benefits and services does the Beneficiary receive?

Medicare	

Medigap Supplement	
Name of Company	
Part D Prescription Coverage	
Name of Company	
Extra Help	
Low income housing (section 8) List amount of subsidy	
Food Stamps	
Hart Supported Living	
Supports for Community living Waiver	
Michelle P Waiver	
Home & Community Based Waiver	
Acquired Brain Injury Waiver	
Acquired Brain Injury Long Term Waiver	
Model II Waiver	
Nursing Home (ICF) - Medicaid	
ICF / IDD - Medicaid	
Private Health Insurance	

10. What assets does the Beneficiary own?

Assets owned by Beneficiary	Check response	Approx. Value
House (individually or joint)	YES □ NO □	
Vehicle(s) (year/make/model)	YES □ NO □	
Checking account	YES □ NO □	
Savings account	YES □ NO □	
Pre-paid burial or funeral plan	YES □ NO □	
Annuity	YES □ NO □	
Other - specify	YES □ NO □	

11. Has the court appointed a legal guardian[4] or conservator[5] for the beneficiary? YES□ NO□

**if so, provide information below and copies of letters of Guardianship and Conservatorship, also called letters of adjudication.*

Check all that Apply: □ Full Guardianship □ Limited Guardianship	□ Full Conservatorship □ Limited Conservatorship
Court that appointed and Case Number:	
Guardian's Name:	
Social Security # or EIN:	
Address:	
City: State: Zip:	
Email address:	Relationship to Beneficiary

12. Has the Social Security Administration appointed a Representative Payee[6]? YES□ NO□

Representative Payee Name:		
Address:		
City:	State:	Zip:
Telephone	Fax:	

13. Has the life beneficiary executed a Durable Power of Attorney[7]? YES□ NO□

**Submit copy of document with signatures. Please note that the Durable Power of Attorney (DPOA) is authorized to sign the trust agreements to establish a trust only if the DPOA specifically delineates powers to open, revoke, or terminate a trust.*

Name:		
Address:		
City:	State:	Zip:
Telephone:	Email:	

14. For Third Party Trusts Only: Complete the following information for the Settlor (s).

Full name of Settlor	Relationship to Beneficiary	Telephone	Email

15. Provide contact information for Remainder Beneficiaries:

Full Name(s) of Remainder Beneficiary (ies)	Relationship to Beneficiary	Telephone	Email

_____ _____

Signature of Person Completing Form Date

_____ _____

Print Name of Person Completing Form Phone