The Arc of Bristol County Pooled Trust
INTAKE APPLICATION

Applicant Residential Information

Beneficiary Name: ______________________________ Age: ______ Date of Birth: _____________________

Address: ______________________________________ SSN: ______________________

____

Phone: ☐ home ______________________________ ☐ cell: ______________________ ☐ other: _______________________

Type of Residence: ☐ own apt ☐ nursing home ☐ assisted living ☐ Adult Foster Care
☐ group home ☐ own condo/house ☐ other: ____

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed
☐ other: _____________________________________(specify)

Children ☐ Yes names and ages: ____
☐ No ____

Day Program:_________________________________ Phone: _____________________ Fax: _________________________

_____________________________________ Email: ____

Applicant Disability Information

☐ Physical Disability ____

☐ Intellectual/Developmental Disability ____

☐ Mental Illness ____

☐ Other ____

____

Assistive Devices: ____

____

Health Status: ____

Applicant Benefit Information

Residential Provider:_____________________________ Phone: _______________ Email: __________________________

Housing Assistance/Subsidy:_______________________ Phone: _______________ Fax: ______________________

Representative Payee:_____________________________ Phone: _______________ Email: __________________________

Income Type(s)
- ☐ Supplemental Security Income (SSI) Amount: $_____________/monthly
- ☐ Social Security Disability Income (SSDI) Amount: $_____________/monthly
- ☐ Social Security Retirement Income (DAC) Amount: $_____________/monthly
- ☐ Wages Amount: $_____________/monthly Employer:___________________
- ☐ Annuity Amount: $_____________/monthly Insurer:____________________
- ☐ Other Specify:____

  Amount: $_____________/monthly

Health Insurance
- ☐ Medicaid/MassHealth Other States Medicaid benefits were received: _______________________________________
- ☐ Medicare ☐ Medicare Prescription Drug Coverage ____
- ☐ Other Health Insurance (private) ____
- ☐ Dental Coverage ____

Pre-need Funeral/Burial Information

Pre-Need Funeral Arrangements: ☐ Yes Contract #:_________________ ☐ No

Funeral Home: ____

Phone: ____

Cemetery: ____

Plot: ________ Lot: ________ Location:____________

(If Applicable) Name of Funeral Trust: ____

Trust Acct: ____

Phone: ____

Signor and Representative Information

Who will be signing the trust documents?

- ☐ **Beneficiary**
- ☐ **Beneficiary's Guardian**
- ☐ **Beneficiary's Conservator**
- ☐ **Grandparent**
- ☐ **Beneficiary's Power of Attorney**
- ☐ **Parent**
- ☐ **Other** ______________________

☐ **Court** _____________________________ Judge__________________

(attach copy of order)

Does the Applicant have a Will?

☐ Yes ☐ No

☐ Copy Attached

Complete only if applicant has a Power of Attorney: (attach copy of POA)

Power of Attorney Name: ____ Phone: ___________________

Address: ____ Date of Appt: ___________________

Email: ____

Complete only if applicant has a court-appointed Guardian and/or Conservator: (attach copy of decree)

Guardian Name: ____ Phone: ___________________

Address: ____ Date of Appt: ___________________

Email: ____

Conservator Name: ____ Phone: ___________________

Address: ____ Date of Appt: ___________________

Email: ____

Applicant Estate Information

Does the applicant own real property? ☐ Yes ☐ No

If Yes, list the address of the property ____

- ☐ The applicant does not occupy the property
- ☐ The property is vacant pending sale ☐ private sale ☐ Real Estate Broker__ _______________________
- ☐ The property is rental income for the applicant
- ☐ Other ____

Does the applicant have a life estate in any real property? ☐ Yes ☐ No

If Yes, list the address of the property ____

Is someone other than the beneficiary living at the property? ☐ Yes ☐ No

Funding Information

Initial Deposit to Trust
*If deposit was subject to a Medicaid or Medicare lien, please submit copes of releases showing any and all liens have been satisfied in full.

Source: ☐ Inheritance Amount: $______________________________

☐ Settlement Amount: $______________________________

☐ Savings Amount: $______________________________

☐ Other Amount: $______________________________ Specify: ______________________________________

Additional Subsequent Deposits to Trust

Source: ☐ Inheritance Amount: $______________________________ Anticipated Date:______________________________

☐ Settlement Amount: $______________________________ Anticipated Date:______________________________

☐ Savings Amount: $______________________________ Anticipated Date:______________________________

☐ Other Amount: $______________________________ Anticipated Date:______________________________

Specify:____

Disbursement Information

Name of Contact Person: ____ Phone: ______________________________________

Email: ____ Relationship: ___________________________________

Distributions:

Legal/Professional____ $_____________

Medical____ $_____________

Personal Care: _______________________________________ $_____________

Cable/Phone/Internet:_____________________________________ $_____________

Subscriptions/Literature:__________________________________ $_____________

Memberships/Clubs:_______________________________________ $_____________

Furnishings/Home Improvement:_____________________________ $_____________

Travel/Vacation:____ $_____________

Other:____ $_____________

____ $_____________

Medical Expenses Not Covered by Insurance: $____________

Specify:____

Applicant Attorney Information

Attorney Name: ____ Office Phone: __________________________________

Address: ____ Office Fax: __________________________________

____ Cell: __________________________________

Email: ____ Other: ____________________________(specify)

Remainderperson/Organization Information

Information about the person and/or organization identified any funds remaining after the beneficiary's death and final settlement costs. The Arc of Bristol County will receive 5% of the remaining assets if the account closes in year 1 and 2. The Arc of Bristol County will receive 25% of the remaining assets if the account closes year 3 and after.

Name: ____ Phone: _______________________________

____ Relationship: _______________________________

____ % of Remaining Funds ______________________

DOB: ____________ SSN/EIN: __________________

If on death of the beneficiary, this person is not then living / organization no longer exists, this gift: ☐ _____lapse ☐ to continent beneficiary (next section)

Name: ____ Phone: _______________________________

____ Relationship: _______________________________

____ % of Remaining Funds ______________________

DOB: ____________ SSN/EIN: __________________

If on death of the beneficiary, this person is not then living / organization no longer exists, this gift: ☐ _____lapse ☐ to continent beneficiary (next section)

Name: ____ Phone: _______________________________

____ Relationship: _______________________________

____ % of Remaining Funds ______________________

DOB: ____________ SSN/EIN: __________________

If on death of the beneficiary, this person is not then living / organization no longer exists, this gift: ☐ _____lapse ☐ to continent beneficiary (next section)

Contingent Remainderperson/Organization Information

Name: ____________________________________ Phone: ______________________________
____________________________________ Relationship: ______________________________
____
DOB: _______________________________ SSN/EIN: ______________________________________

Name: ____________________________________ Phone: ______________________________
____________________________________ Relationship: ______________________________
____
DOB: _______________________________ SSN/EIN: ______________________________________

OR Heirs at law

Other Information

Person completing this form:

Name: ________________________________ Phone: ___________________
________________________________ Relationship: ___________________
________________________________ Email: ___________________

Account Reporting

After an account has been set up, the beneficiary is legally required to report it to Social Security (if he or she receives SSI) or to the Massachusetts Medicaid agency ("MassHealth") if he or she is eligible for MassHealth, but not for SSI.

An attorney who works regularly with *The Arc of Bristol County Pooled Trust* will assist you in fulfilling your legal duty to report the account to the correct government agency. If you have an attorney representing you, he will prepare a letter and supporting materials to your personal attorney, who will then use them to report the account to Social Security or MassHealth. If you are not personally represented by an attorney, he will prepare a reporting letter on your behalf with supporting materials directly to Social Security or MassHealth. The bill for the legal work necessary to satisfy your legal duty to report your account will be paid from your trust account.

Please indicate which procedure the attorney should follow on your behalf by circling one of the following:

□ I direct the attorney to work with my personal attorney, to take primary responsibility for reporting the account to Social Security or MassHealth.
□ I direct the attorney to report the account directly to Social Security or MassHealth on my behalf.

Fee Schedule

The Arc of Bristol County Pooled Trust requires a minimum account of $5,000.00 (five thousand dollars). However, this amount requirement may be waived for hardship cases at the discretion of the President and CEO in his/her capacity serving as Trustee for the agency.

Applicant's fee for enrollment:
□ **$475** without a guardian, conservator, power of attorney or other fiduciary
□ **$575** with a guardian, conservator, power of attorney or other fiduciary

Please complete the application, attach the required documentation, and the enrollment fee check payable to:

The Arc of Bristol County
141 Park Street
Attleboro, MA 02703

$ __________ represents the assets to fund the trust. Please make the check payable to **The Arc of Bristol County**

Pooled Trust. Kindly note the memo to state "for the benefit of ___________________" (name of beneficiary).

5% of remainder is kept by The Arc of Bristol County Pooled Trust before MassHealth Estate Recovery if account is closed in year one and two.
25% of remainder is kept by The Arc of Bristol County Pooled Trust before MassHealth Estate Recovery if account is closed in year three and after.

Annual Fees for services: $250 minimum or 2% of the sub account.

The undersigned Sponsor herby wishes to establish a trust account under The Arc of Bristol County Pooled Trust on behalf of the Designated Beneficiary. The trust account shall be governed by the terms and conditions of The Arc of Bristol County Pooled Trust.

□ I understand this Agreement is irrevocable, however I may add or substitute residual remainder persons listed.

□ If the Guardian and/or Conservator is signing the trust documents for the beneficiary, the decree(s) and court orders allowing the authority to establish this estate plan <u>MUST</u> be submitted with this application.

Sponsor:

Printed Name:___________________________________

Signature: ___________________________________ Date: _____________________