The Arc
Bristol County

The Arc of Bristol County, Inc
Family Pooled Trust
INTAKE APPLICATION

Donor and Representative Information

Who will be signing the trust documents?

☐ **Donor**

Name: _____

Address: _____

SSN: _____

Email: _____

Telephone Number(s): _____

Date of Birth:_____

Relationship to Beneficiary:_____

Funding Information

Please provide a brief description of the amount of funds you plan to deposit into the pooled trust account and the origin of the funds.

(Examples: "from a life insurance policy", "from my estate", "distribution from my revocable trust", etc.)

_____

_____

_____

_____

Beneficiary 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: _____

Beneficiary Disability Information

☐ Physical Disability _____

☐ Intellectual/Developmental Disability _____

☐ Mental Illness _____

☐ Other _____

_____

Assistive Devices: _____

_____

Health Status: _____

Beneficiary Benefit Information

Residential Provider:_____ Phone: _____ Email/Fax: _____

Housing Assistance/Subsidy:_____ Phone: _____ Email/Fax: _____

Representative Payee:_____ Phone: _____ Email/Fax: _____

Income Type(s)
- ☐ Supplemental Security Income (SSI) Amount: $_____/monthly
- ☐ Social Security Disability Income (SSDI) Amount: $_____/monthly
- ☐ Social Security Retirement Income (based on earnings of beneficiary) Amount: $_____/monthly
- ☐ Social Security Disabled Adult Child (DAC based on earnings of parent(s)) Amount: $_____/monthly
- ☐ Wages Amount: $_____/monthly Employer:_____
- ☐ 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 For The Beneficiary

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

Funeral Home: _____

Phone: _____

Cemetery: _____

Plot: _____ Lot: _____ Location:_____

(If Applicable) Name of Funeral Trust: _____

Trust Acct: _____

Phone: _____

Does the Beneficiary have a Will? ☐ Yes ☐ No

☐ Copy Attached

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

Power of Attorney Name: _____ Phone: _____

Address: _____ Date of Appt: _____

Email: _____

Complete only if Beneficiary 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: _____

Beneficiary Real Estate Information

Does the beneficiary own real property? ☐ Yes ☐ No

If Yes, list the address of the property _____

- ☐ Does the beneficiary occupy the property ☐ Yes ☐ No
- ☐ The property is vacant pending sale ☐ private sale ☐ Real Estate Broker__ _____
- ☐ The property is rental income for the applicant
- ☐ Other _____

Does the beneficiary 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

Disbursement Information

Name of Contact Person: _____ Phone: _____

Email: _____ Relationship to Beneficiary:_____

_____

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:_____

_____

_____

Beneficiary Attorney Information

Attorney Name: _____ Office Phone: _____

Address: _____ Office Fax: _____

_____ Cell: _____

Email: _____ Other: _____(specify)

Remainderperson/Organization Information and Contingent

Information about the person and/or organization identified any funds remaining after the beneficiary's death and final settlement costs.

Remainder Share for Charity

If you wish, you may designate a share of the trust assets remaining at the time of the Beneficiary's death to go to The Arc of Bristol County, Inc. in furtherance of its charitable mission. Funds designated for this charitable purpose will be used to assist other individuals with intellectual and developmental disabilities as well as to defray the ongoing administrative expenses of operating The Arc of Bristol County, Inc. Family Pooled Trust.

Please indicate what percentage, if any, of the remaining trust assets you wish to designate to The Arc of Bristol County, Inc., for its charitable purposes:

50% ____ 25% ____ Other: _____

Remainder Beneficiaries for Net Trust Balance

Please indicate the remainder-person(s) or organization(s) you wish to receive the net remaining trust assets, after payment of expenses of final trust settlement and any share designated to the charity.

1. Name: _____ Phone Number: _____
Address: _____ Relationship to Beneficiary: _____
_____ Percentage of Remainder: _____

2. Name: _____ Phone Number: _____
Address: _____ Relationship to Beneficiary: _____
_____ Percentage of Remainder: _____

3. Name: _____ Phone Number: _____
Address: _____ Relationship to Beneficiary: _____
_____ Percentage of Remainder: _____

4. Name: _____ Phone Number _____
Address: _____ Relationship to Beneficiary: _____
_____ Percentage of Remainder: _____

Alternate Remainder-person(s) or Organization(s):

For each remainder-person you have designated above, please describe your testamentary wishes if he or she has died before the trust beneficiary's death and final distribution of the trust:

_____

_____

_____

_____

_____

_____

_____

Other Information

Person completing this form:

Name: _____ Phone: _____

_____ Relationship to Beneficiary: _____

_____ Email: _____

☐ I understand this that the account for the beneficiary is irrevocable once it has been funded, but that I retain the right to change the remainder-person(s) I have designated so long as I do so on a form acceptable to The Arc of Bristol County, Inc, and no more often than once each year.

Donor:

Printed Name:_____

Signature: _____ Date: _____

2/26/18 Revised