



The Arc of Bristol County Pooled Trust INTAKE APPLICATION

Applicant 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 (specify)
☐ other: _____

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)	<input type="checkbox"/> Supplemental Security Income (SSI) Amount: \$ _____/monthly	Amount: \$ _____/monthly
<input type="checkbox"/> Social Security Disability Income (SSDI)	Amount: \$ _____/monthly	Amount: \$ _____/monthly
<input type="checkbox"/> Social Security Retirement Income (DAC)	Employer: _____	Amount: \$ _____/monthly
<input type="checkbox"/> Wages	Insurer: _____	
<input type="checkbox"/> Annuity		
<input type="checkbox"/> Other (please specify): _____		
	Amount: \$ _____/monthly	

Health Insurance	<input type="checkbox"/> Medicaid/MassHealth Other States Medicaid benefits were received: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Prescription Drug Coverage _____ <input type="checkbox"/> Other Health Insurance (private) _____ <input type="checkbox"/> Dental Coverage _____
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Pre-need Funeral/Burial Information

Pre-Need Funeral Arrangements:	<input type="checkbox"/> Yes Contract #: _____	<input type="checkbox"/> No
Funeral Home:	_____	
Phone:	_____	
Cemetery:	_____	
	Plot: _____	Lot: _____ Location: _____

(If Applicable)	Name of Funeral Trust: _____ Trust Acct: _____ Phone: _____
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Signor and Representative Information

Who will be signing the trust documents?

- | | | |
|---|---|---|
| <input type="checkbox"/> Beneficiary | <input type="checkbox"/> Beneficiary's Guardian | <input type="checkbox"/> Beneficiary's Power of Attorney |
| | <input type="checkbox"/> Beneficiary's Conservator | <input type="checkbox"/> Parent |
| | <input type="checkbox"/> Grandparent | |
| | <input type="checkbox"/> Other _____ | |
| | <input type="checkbox"/> Court _____ | Judge _____ |
- (attach copy of order)

Does the Applicant have a Will?☐ Yes (Please attach copy)☐ No**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 copies 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 TrustSource: ☐ Inheritance Amount: \$ _____☐ Settlement Amount: \$ _____☐ Savings Amount: \$ _____☐ Other Amount: \$ _____

Anticipated Date: _____

Anticipated Date: _____

Anticipated Date: _____

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:

- ☐ direct the attorney to work with my personal attorney, to take primary responsibility for reporting the account to Social Security or MassHealth.
- ☐ 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
Attn: Trust Services
16 Hillside Avenue
Attleboro, MA 02703

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

Kindly note the memo to state "for the benefit (f/b/o) 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: Consistent with Fee Schedules.

The undersigned Sponsor hereby 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 MUST be submitted with this application.

Sponsor:

Printed Name: _____

Signature: _____

Date: _____