Please complete this questionnaire so we can provide the best service possible.

Grantor Information

Grantor Name: □ Mr./□ Ms. _____

Home Address: _____

City: _____State: _____Zip:_____

Telephone (day) number:_____ Cell number:_____

Email Address: _____

Relationship To Beneficiary:_____

How should we deliver the Welcome Packet? ☐ **Mail** ☐ **Email**

Beneficiary Information

Beneficiary Name: □ Mr./□ Ms. _____

Present Address: _____

City: _____State: _____Zip:_____

Telephone (day) number:_____Social Security #_____

Email Address: _____

Date of Birth:_____ Place of Birth:_____

Medicaid Number (if any):_____

Trust's Tax ID Number: _____

If the Beneficiary is a Minor, please provide:

Mother's Name:_____ SS#_____

Father's Name:_____ SS#_____

If the Beneficiary has a legal representative (such as a legal guardian, conservator, representative payee, power of attorney or other agent) please provide the following information and a copy of the corresponding documentation (**if same as Grantor, please indicate):**

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: (day)_____(cell)_____

Email Address: _____

Relationship: _____

What is the Beneficiary's disability? Also, if the Beneficiary's condition has been medically diagnosed, what is the diagnosis?

_____

_____

_____

_____

_____

What is the Beneficiary's current Prognosis?

_____

_____

_____

Your Attorney

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone Number:_____ Fax Number:_____

Email: _____

Government Assistance

Type and Amount of Monthly Income

(Please include a copy of the most recent Award Notice from Social Security or state Medicaid Agency)

Social Security Retirement…… Yes_____ No_____ Amount $_____

Social Security Disability Insurance (SSDI)……Yes_____ No_____ Amount $_____

Disabled Adult Child (DAC) or Childhood Disability Benefits (CDB) Yes_____ No_____ Amount $_____

Supplemental Security Income (SSI) …….. Yes_____ No_____ Amount $_____

Government Assistance Programs

Institutional Care Program (ICP) or Statewide Medicaid Managed Care Program for Long Term Care (SMMC-LTC) (Nursing Home and Long Term Care)…….. Yes_____ No_____ Applying for _____

Home or Community Based Medicaid Waiver Programs… Yes_____ No_____ Applying for _____

PACE……..……... Yes_____ No_____ Applying for _____

Medically Needy Program….....Yes_____ No_____ Applying for _____

Statewide Medicaid Managed Care Managed Medical Assistance (SMMC-MMA)…… Yes_____ No_____ Applying for _____

Optional State Supplementation (OSS)…… Yes_____ No_____ Applying for _____

Food Assistance…….. Yes_____ No_____ Applying for _____

Veteran's Benefits…….. Yes_____ No_____ Applying for _____
(Aid and Attendance)

(**Circle One)** Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB) or Qualifying Individuals 1 (QI1)……Yes_____ No_____ Applying for _____

List **any other** government assistance that the Beneficiary receives or has applied for:

List all forms of government assistance (including Medicaid programs in Florida or any other state) which have been denied or discontinued to the Beneficiary, including the approximate dates:

Insurance Information

If the Beneficiary is covered under any policy of health care insurance other than Medicaid, please provide the following:

Insuring Company: _____

Policy Number: _____

If the Beneficiary is covered under any prepaid funeral or burial policy or insurance, please provide the following:

Company: _____

Address: _____

_____

Policy Number: _____

We strongly suggest prepaying for funeral or burial arrangements as the Trust cannot pay for these expenses after the death of the Beneficiary.

DESIRES OF GRANTOR FOR USE OF DISTRIBUTIONS FROM TRUST DURING LIFE OF BENEFICIARY

Please be as thorough as possible when completing this section.
This information is very important when authorizing requests for distributions.

Please explain how you would like to see assets in the Beneficiary's account used to improve the Beneficiary's quality of life. We may require a spending plan under certain circumstances. If so, we will let you know. If so, we will let you know. Please note that you will NOT be limited to only those items or services listed here.

Please fill out the questions below to assist in the distribution process.

Does the trust beneficiary have an ABLE account? ☐ **YES** ☐ **NO**

Does the trust beneficiary own a home? ☐ **YES** ☐ **NO**

If yes, please provide the address:

Does the trust beneficiary own a vehicle? ☐ **YES** ☐ **NO**

Is the trust beneficiary married? ☐ **YES** ☐ **NO**

If yes, please provide the spouse's name: _____

Does the trust beneficiary have children? ☐ **YES** ☐ **NO**

If yes, please provide their names and date of birth:

If possible, please provide the name and address of anyone who can be consulted if reassessing the Beneficiary's supplemental needs becomes useful or necessary in the future. Examples might include family members, a care manager, or even a care management company. *Please indicate whether you would like for each person to be able to request distributions*.

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Understanding Regarding Legal Advice and Distributions from Trust

Please **initial each item** and **sign** below to acknowledge an understanding that:

____ Neither the Non-Profit Trustee, the Co-Trustees, nor any of their employees or agents, have offered or given me any legal advice regarding the Trust, the suitability of the Trust as it may apply to my individual circumstances or to the individual circumstances of the Beneficiary. I have been encouraged to, and have had a full, complete, and fair opportunity to, seek independent tax and legal counsel.

____ I understand there will be limitations on how funds may be utilized, including the fact that no payments may be made directly to a Beneficiary and all distributions must directly benefit only the Beneficiary (no gifting);

____ I understand that debts incurred prior to the establishment of the Trust may not be approved/paid. Please consult with your attorney about satisfying all debt prior to the establishment of the Trust;

____ Each request for a distribution must be accompanied by a Distribution Request Form (provided in the Welcome Packet) and a bill, receipt and/or proof of payment for the expenditure that solely benefits the Beneficiary;

____ No distributions may be made after the death of a Beneficiary, including funeral or cremation expenses and I have been advised to prearrange for these services;

____ If the Beneficiary is receiving Supplemental Security Income (SSI) there will be additional restrictions regarding distributions which will be detailed in the Welcome Packet;

____ If I request that an individual is to be paid for services rendered to the Beneficiary, and the individual providing these services is not in the routine business of providing such services, the individual will be paid through a third-party employment service at no additional cost to the Beneficiary;

____ I understand that the Trustee shall be compensated pursuant to their usual and customary fees. Additional fees may be assessed for individual money management, accounting services, legal services, or the management of unique assets such as real property or mineral interests.

Dated the ____ day of_____, _____.

_____

Grantor