The Arc
Bristol County

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
☐ 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 (please 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 Power of Attorney**
- ☐ **Beneficiary's Conservator**
- ☐ **Parent**
- ☐ **Grandparent**
- ☐ **Other _____**
- ☐ **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 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
Attn: Trust Services
16 Hillside Ave
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: Consistent with Fee Schedules.

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 MUST be submitted with this application.

Sponsor:

Printed Name:_____

Signature: _____ Date: _____

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