Life's WORC | Trust Services
Financial Security for People with Special Needs.

Trust Intake Form

1. Type of Trust to be established (check all that apply):
   a. Pooled Self-Settled _____
   b. Pooled Third Party _____
   c. Surplus Income _____
   d. Independent/ Private SNT _____

2. Is this trust ordered by the court? Yes, _____ No _____ *(provide copy of court documents)*

3. Is there a Court-Appointed Guardian for the beneficiary? Yes _____ No _____

   a. Name of Guardian _____ *(provide Letters of Guardianship)*

   b. Guardian of **Person**: Yes _____ No _____ **Property**: Yes _____ No _____

4. Name of Sponsor/ Grantor (usually the Beneficiary or Guardian) _____

   Or name of primary contact (if different) _____

   Address: _____

   Telephone (Day) _____ (Evening) _____

   Email: _____

5. Full Name of Designated Beneficiary: _____

   Social Security No: _____ (*include a copy of the beneficiary's Social Security Card with this form*)

   Current/ Permanent Address: _____

   _____

   Telephone (Day) _____ (Evening) _____

6. Date of Birth: _____

   Country of Birth: _____ Country of Citizenship: _____

   Alien Registration No: _____ *(attach copy of Green Card)*

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trustservices@lifesworc.org I www.lifesworctrust.org

Gender: Male _____ Female _____

7. Has the beneficiary been determined to be permanently disabled? Yes_____ No _____

   List all qualifying disabilities _____

   _____

   (Copy of psychological, psychosocial, medical reports may be required)

8. Identify all sources of the beneficiary's income (check all that apply) and provide proof of income

   a. Supplemental Security Income (SSI) _____
   b. Social Security Disability (SSDI) _____
   c. Social Security Retirement Income (SSA) _____
   d. Currently Employed _____
   e. Other Income _____ (please specify, e.g. Pension etc.) _____

9. List all financial institutions where resources are held _____

   _____

10. Does the beneficiary have current medical insurance including Medicaid? Yes _____ No _____

    Insurance Type _____ INS ID #: _____

11. Will this account be used to shelter excess income for Medicaid purposes? Yes _____ No _____

12. Indicate the amount of the monthly deposit _____ *(attach copy of Medicaid Notice of Decision)*

13. Does the beneficiary have resources other than those identified above? Yes _____ No _____

    Please provide details _____

14. Provide a list of the beneficiary's monthly expenses _____

    _____

15. Indicate any immediate needs of the beneficiary:

    _____

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16. Indicate who should receive monthly statements of the beneficiary's account:

    Name _____ relationship _____

17. Indicate who is authorized to make disbursement requests on the beneficiary's behalf:

    Name _____ relationship _____

    Name _____ relationship _____

18. Who will be responsible for submitting the Trust documents to Medicaid, Social Security Administration or other government agency on behalf of the beneficiary?

    Name _____

    Telephone _____ (alternate) _____

    Email _____

    Agency/Firm _____

    Address _____

19. Additional Information:

    _____

    _____

    _____

    The information provided above is accurate and complete to the best of my knowledge.

    _____ _____
    Sponsor/Beneficiary/Guardian/POA Date

    _____ _____
    Witness Date

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