The Arc. Northern Virginia
Special Needs Trust Serving DC, MD, & VA

Trust Department
The Foundation of The Arc of Northern Virginia
2755 Hartland Road, Suite 200
Falls Church, VA 22043
703-208-1119

Trust Plan - Part A: Beneficiary Profile

The purpose of the trust Plan (Parts A and B) is to inform the Director of Trusts' decisions regarding expenditures on behalf of the Beneficiary. The Foundation's Trust Team is responsible for reviewing, approving and processing payments for goods and services needed by the Beneficiary. The content in the Trust Plan helps the Foundation's Trust team ensure that expenditures are aligned with the Beneficiary's needs by providing information about the individual's family, his/her disability, health issues, trusted representatives, benefits and income sources, and daily life. Although it is ultimately the Primary Representative's responsibility to arrange for and monitor the delivery of goods and services to the Beneficiary, the Foundation, as Manager of the Trust, ensures trust disbursements are fully documented, consistent with the Grantor's objectives for the Beneficiary, aligned with the Beneficiary's needs and previous spending patterns, and in keeping with government benefits eligibility requirements.

BENEFICIARY (Full Name): ______________________________

ADDRESS: ______________________________

PHONE(S): ______________ / ______________

EMAIL: ______________ **DATE:** ______________

I. BENEFICIARY'S FAMILY

A. PARENTS

MOTHER

Full Name: ______________________________

Address: ______________________________

City: ____________ **State:** __ **Zip Code:** ________ **County:** ______

Phone: ______________ / ______________

Email: ______________________________

Marital Status: ☐ Married ☐ Divorced ☐ Widowed

FATHER

Full Name: ______________________________

Address: ______________________________

City: ____________ **State:** __ **Zip Code:** ________ **County:** ______

Phone: ______________ / ______________

Email: ______________________________

Marital Status: ☐ Married ☐ Divorced ☐ Widowed

B. SIBLINGS

Name	Married?	# of Children?	Birth Year
______________________	☐ Yes ☐ No	_______	_______
______________________	☐ Yes ☐ No	_______	_______
______________________	☐ Yes ☐ No	_______	_______
______________________	☐ Yes ☐ No	_______	_______
______________________	☐ Yes ☐ No	_______	_______

C. ADVISORS

	Attorney	Telephone No.	Address	Will Executed?
Mother's				☐Yes ☐ No Date
Father's				☐Yes ☐ No Date

II. BENEFICIARY

A. DISABILITIES

Primary Disability: Briefly describe the Beneficiary's **primary** disability (diagnosis, when diagnosed, principal symptoms/manifestations, coping strategies, therapies etc.).

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Secondary Disability: Briefly describe the Beneficiary's **other disability(ies):** diagnosis, when diagnosed, principal symptoms/manifestations, coping strategies, therapies etc.

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B. BACKGROUND

Describe key milestones, transitions and individuals in the Beneficiary's childhood and adult life thus far. Please attach additional pages if needed.

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III. Current Situation

Describe ***each*** of the following aspects of the Beneficiary's ***current*** situation. Please attach additional pages if needed.

Residential:

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Medical / Dietary Needs and Restrictions:

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Medications and Pharmacy:

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Hospitalizations:

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Current Services and/or Programs:

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Strengths:

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Limitations:

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IV. BENEFICIARIES REPRESENTATIVES

A. Guardianship

1. Is the Beneficiary his/her own Guardian? ☐ Yes ☐ No
2. If NO, provide the following information about the Beneficiary's Guardian:

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone **Day** ______________ **Evening** ______________

Email ______________________________

Date of Guardianship Court Order ______________________________

☐ **A Copy of the Court Order Has Been Given/Mailed to The Foundation of The Arc of Northern Virginia.**

B. Representative Payee

1. Does the Beneficiary have a Representative Payee? ☐ Yes ☐ No
2. If so, provide the following information about the Beneficiary's Representative Payee:

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone **Day** ______________ **Evening** ______________

Email ______________________________

Date Rep Payee Letter of Awards ______________________________

☐ **A Copy of the Letter of Awards Indicating Rep. Payee or Rep Payee Status Has Been Given/Mailed to The Foundation of The Arc of Northern Virginia.**

C. Conservator

1. Does the Beneficiary have a Conservator? ☐ Yes ☐ No
2. Does the Beneficiary have a Limited Conservator? ☐ Yes ☐ No
3. If the answer to #1 or #2 is yes, provide the following information about the Beneficiary's Conservator/Temporary Conservator:

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone **Day** ______________ **Evening** ______________

Email ______________________________

Date of Conservatorship Court Order ______________________________

☐ **A Copy of the Court Order Has Been Given/Mailed to The Foundation of The Arc of Northern Virginia.**

D. Power of Attorney (POA)

1. Does the Beneficiary have a Power of Attorney? ☐ Yes ☐ No
2. What type of POA(s) does the Beneficiary have ? (check all that apply)
   ☐ Durable ☐ Medical ☐ Psychiatric ☐ Other
3. If so, provide the following information about each Power of Attorney. Please use additional pages if necessary:

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone **Day** ______________ **Evening** ______________

Email ______________________________

Date of Power of Attorney Documentation ______________________________

☐ **A Copy of each of the POA Documents identified on the previous page has been given/mailed to The Foundation of The Arc of Northern Virginia.**

E. Is there any other legal authority (such as Health Proxy, Child Custody Agreement, etc.) The Foundation of The Arc of Northern Virginia should know about? If so, please provide the information below:

Name ____

Address ____

City, State, Zip ____

Phone Day ________________________ Evening ________________________

Email ____

Date of Relevant Document ____

☐ A Copy of the Document Has Been Given/Mailed to The Foundation of The Arc of Northern Virginia.

V. GUIDANCE FOR THE FUTURE

A. LIVING SITUATION

What are the Beneficiary's wishes and your own wishes concerning his or her living arrangements after your death?

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B. EDUCATION and/or VOCATIONAL TRAINING

Is the Beneficiary enrolled in an education or vocational/employment training program? If so, please describe the Beneficiary's activities, level of involvement. Provide name and address of the organization, name of contact person and phone number.

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C. TRUST DISBURSEMENTS

Please describe the Beneficiary's ability to manage money and to make decisions about money:

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How would the Grantor(s) prefer the money in the trust be spent? For example, "to supplement government benefits by paying for recreation, dental care, special equipment, and 2 annual vacations." Note: A detailed budget and plan will be prepared in Part B of the Trust Plan.

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What should the trust funds NOT pay for? Please be as specific as possible.

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D. FUNERAL ARRANGEMENTS

Describe arrangements already in place for the Beneficiary's funeral. Please include names and phone numbers for funeral homes and others involved OR provide copies of arrangement contracts to The Foundation 's Trust Department.

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☐ **A Copy of the pre-need arrangement described above has been given to The Foundation of The Arc of Northern Virginia.**

If you have not yet established funeral/burial/cremation or other *pre-paid* arrangements for the Beneficiary, please select those arrangements in the table below which you would *prefer* for the Beneficiary (Note: by indicating your preference, you are simply conveying your wish(es), not obligating the trust to pay for these services . Only Primary Representatives may authorize and become responsible for trust disbursements for pre-need arrangements such as those listed below. Please remember: once a Self-Funded trust Beneficiary passes away, the Self-Funded Special Needs Trust funds cannot be disbursed for any reason (including burial, funeral, cremation and other related services). On the other hand, a Family-Funded trust sub account, can remain open after the Beneficiary's date of death to pay for burial/funeral/cremation arrangements. (Section H.1, FF Joinder Agreement).

	Type of Arrangement	Preference
1	Irrevocable Burial Insurance	☐ Prefer ☐ Prefer Not
2	Cemetery Plot	☐ Prefer ☐ Prefer Not
3	Funeral Arrangements	☐ Prefer ☐ Prefer Not
4	Cremation Arrangements	☐ Prefer ☐ Prefer Not
5	Donate to Science	☐ Prefer ☐ Prefer Not

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Trust Plan - Part B:

Benefits, Employment & Other Financial Information

BENEFICIARY (Full Name): ____

I. Benefits, Income & Insurance

A. BENEFITS: Please, send a copy of your most recent Notice of Award letter(s) to the Foundation's Trust Department.

	Benefit Program		Monthly Income
1	SSI[1]	☐Yes	$ ________________________/month
		☐ No	
2	SSDI[2]	☐Yes	$ ________________________/month
		☐ No	
3	Annuity[3]	☐Yes	$ ________________________/month
		☐ No	
4	Veteran's Benefits	☐Yes	$ ________________________/month
		☐ No	
5	Survivor Benefits	☐Yes	$ ________________________/month
		☐ No	
6	Food Stamps (SNAP)[4]	☐Yes	$ ________________________/month
		☐ No	
7	Section 8 or Housing Assistance/Voucher	☐Yes	$ ________________________/month
		☐ No	
	[Rent Paid by Client:]	☐Yes	$ _______________________/month
		☐ No	

[1] Supplemental Security Income
[2] Social Security Disability Insurance.
[3] Investment vehicle offered by insurance companies which guarantees a stream of fixed payments over the life of the annuity.
[4] Supplemental Nutrition Assistance Program (SNAP).

List Other Benefits Below:

	Benefit ($/month)	Source	Start Date	ID/Account/Policy No.
1	______	______	______	______
2	______	______	______	______

B. Have you intentionally decided against applying for benefits on behalf of the Beneficiary? If so, please explain why.

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C. Would you recommend sacrificing benefits to enable the Beneficiary to access more trust funds in certain circumstances? Please explain.

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D. IF EMPLOYED:

Employment Income **$ ______ /month OR $ ______ /biweekly**

Employer/ [Business or Organization] Name ______________________________

Employer Address ______________________________

____

City **State** **Zip Code**

Contact Person ______________________________

Name **Position**

Employer Phone Number ______________________________

E. HEALTH INSURANCE

Provider	Account/Policy Number & Information
MEDICAID (Current):	Medicaid No. ______________________
☐ Virginia ☐ Maryland ☐ Dist. of Columbia ☐ Other: ____________	Medicaid Waiver? ☐ Yes ☐ No Waiver Type: ______________________[5]
Previous MEDICAID State (if any): ☐ Virginia ☐ Maryland ☐ Dist. of Columbia ☐ Other: ____________	Previous Medicaid No. ______________________ Previous Medicaid Waiver? ☐ Yes ☐ No Previous Waiver Type: ______________________
MEDICARE ☐ Yes ☐ No	Medicare No. ______________________
Private Insurance 1	Policy No. ______________________ Name of Policy Holder: ______________________ Company: ______________________ Address: ______________________ Address: ______________________ City: ______________ State: ________ Zip: ______________ Phone: ______________________
Private Insurance 1	Policy No. ______________________ Name of Policy Holder: ______________________ Company: ______________________ Address: ______________________ Address: ______________________ City: ______________ State: ________ Zip: ______________ Phone: ______________________

[5] For example, in Virginia, there are ID, EDCD, and DD Waivers; in Maryland, there are: Community Pathways and New Direction Waivers for Individuals with Developmental Disabilities, Waiver for Adults with Traumatic Brain Injury, Waiver for Children with Autism Spectrum Disorder, Model Waiver for Disabled Children, Waiver for Older Adults, and Living at Home Waiver Program.

F. **PLANNING**

A. Worksheet of Supplemental Expenses

Prepare a realistic budget for the Beneficiary's supplemental expenses using the table below. Completing this table will help you prioritize those expenses the Special Needs Trust could pay for.

	Personal Needs	**Monthly Expense**		**Medical/Dental Care**	**Monthly Expense**
1	Hair & Beauty		17	Dental Care	
2	Telephone		18	Therapy	
3	Cell Phone		19	Well Check-up/Sick Visits	
4	Internet Service		20	Medication	
5	Cable		21	Eye Exams	
6	Books, Magazines		22	Glasses/Contact Lenses	
7	Over the counter drugs			**Subtotal:**	
8	Clothing & Shoes			**Household**	
9	Transportation		23	Cleaning	
10	Vitamins/Specific Diet		24	Repairs	
11	Groceries		25	Maintenance	
	Subtotal:			**Subtotal:**	
	Special Equipment			**Entertainment**	
12	Computer/tablet/other technology		26	Dining Out	
13	Audio Books		27	Sporting Events	
14	Hearings Aids/Batteries		28	Movies	
15	Wheelchair		29	Recreation	
16	Other Adaptive Equipment		30	Camps	
	Subtotal:		31	Vacation	
			32	DVDs, Videos, Games, Software	
			33	Religious Organization/Activities	
			34	Pet Care and Supplies	
				Subtotal:	

Total Monthly Estimate: ____________________

B. TRUST SPENDING PLAN

Using the Beneficiary's Worksheet of Supplemental Expenses on the previous page, list the regular and one-time payments you would like covered via disbursements from the trust. Use the table below and additional pages if necessary (the top two shaded rows illustrate examples only).

	Purpose	Vendor/Payee Name	$/month	Trust Will Pay?
Ex. 1	*Cell phone*	*Verizon Wireless* *P.O. Box 2500* *Phila., PA 19017*	*$100.88*	■ Yes ☐ No
Ex. 2	*Therapist*	*Dr. Jane Doe* *100 Center Street, Suite 22* *Falls Church, VA 22202*	*$35.00*	■ Yes ☐ No
1	___	___ ___ ___	___	☐ Yes ☐ No
2	___	___ ___ ___	___	☐ Yes ☐ No
3	___	___ ___ ___	___	☐ Yes ☐ No
4	___	___ ___ ___	___	☐ Yes ☐ No
5	___	___ ___ ___	___	☐ Yes ☐ No
6	___	___ ___ ___	___	☐ Yes ☐ No
7	___	___ ___ ___	___	☐ Yes ☐ No
8	___	___ ___ ___	___	☐ Yes ☐ No

The Trust Plan is not a legal document. It is an evolving, planning tool intended to support and facilitate the work of The Foundation's Trust Department. The Trust Plan is a living document which may be amended at any time but which should be revisited at least annually.