

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.

	<u>Benefit Program</u>	<u>Monthly Income</u>
1	SSI ¹	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
2	SSDI ²	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
3	Annuity ³	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
4	Veteran's Benefits	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
5	Survivor Benefits	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
6	Food Stamps (SNAP) ⁴	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
7	Section 8 or Housing Assistance/Voucher	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> No
	[Rent Paid by Client:]	<input type="checkbox"/> Yes \$ _____/month <input type="checkbox"/> 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.

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

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):

Previous Medicaid No. _____

- Virginia
- Maryland
- Dist. of Columbia
- Other: _____

Previous Medicaid Waiver? Yes No

Previous Waiver Type: _____

MEDICARE

Medicare No. _____

- Yes No

Health Insurance Premium Program (HIPP)

HIPP No. _____

HIPP for Kids

HIPP for Kids 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	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Ex. 2	Therapist	Dr. Jane Doe 100 Center Street, Suite 22 Falls Church, VA 22202	\$35.00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
1	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	_____	_____ _____ _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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.