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

[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): ☐ Virginia ☐ Maryland ☐ Dist. of Columbia ☐ Other: _____	**Medicaid No. _____** **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. _____**
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*	■ 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.