GUARDIAN TRUST
EST. 2002

Primary Contact Information

Name: □ Mr./□ Ms. _____

Home Address: _____

City: _____State: _____Zip:_____

Telephone (day) number:_____ Cell number:_____

Email Address: _____

Relationship To Trust Beneficiary:_____

How should we deliver the Welcome Packet? ☐ **Mail** ☐ **Email**

Beneficiary Information

Beneficiary Name: □ Mr./□ Ms. _____

Present Address: _____

City: _____State: _____Zip:_____

Telephone (day) number:_____

Social Security #_____

Email Address: _____

Date of Birth:_____

Medicaid Number (if any):_____

If applicable, what is the Beneficiary's disability? Also, if the Beneficiary's condition has been medically diagnosed, what is the diagnosis?

_____

_____

_____

_____

Attorney

Attorney Name: □ Mr./□ Ms. _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

If the Beneficiary has a **legal representative** (such as a legal guardian, conservator, representative payee, power of attorney or other agent) please provide the following information:

Name: □ Mr./□ Ms. _____

Address: _____

Telephone: (day) _____ (cell) _____

Email Address: _____

Relationship: _____

Insurance Information

If the Beneficiary is covered under any policy of private health care insurance, please provide the following:

Insuring Company: _____

Policy Number: _____

If the Beneficiary is covered under any prepaid funeral or burial insurance, please provide the following:

Company: _____

Address: _____

_____

Policy Number: _____

Government Assistance (if applicable)

Type and Amount of Monthly Income

(Please include a copy of the most recent Award Notice from Social Security or state Medicaid Agency)

Social Security Retirement…… Yes_____ No_____ Amount $_____

Social Security Disability Insurance (SSDI)……Yes_____ No_____ Amount $_____

Disabled Adult Child (DAC) or Childhood Disability Benefits (CDB) Yes_____ No_____ Amount $_____

Supplemental Security Income (SSI) …….. Yes_____ No_____ Amount $_____

Government Assistance Programs

Institutional Care Program (ICP) or Statewide Medicaid Managed Care Program for Long Term Care (SMMC-LTC) (Nursing Home and Long Term Care)…….. Yes_____ No_____ Applying for _____

Home or Community Based Medicaid Waiver Programs… Yes_____ No_____ Applying for _____

PACE……..……... Yes_____ No_____ Applying for _____

Medically Needy Program….....Yes_____ No_____ Applying for _____

Statewide Medicaid Managed Care Managed Medical Assistance (SMMC-MMA)…… Yes_____ No_____ Applying for _____

Optional State Supplementation (OSS)…… Yes_____ No_____ Applying for _____

Food Assistance…….. Yes_____ No_____ Applying for _____

Veteran's Benefits…….. Yes_____ No_____ Applying for _____
(Aid and Attendance)

(**Circle One)** Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB) or Qualifying Individuals 1 (QI1)……Yes_____ No_____ Applying for _____

List **any other** income and/or assistance that the Beneficiary receives, has applied for or has been denied in the past:

DESIRES FOR USE OF DISTRIBUTIONS FROM TRUST DURING LIFE OF BENEFICIARY

Please be as thorough as possible when completing this section.
This information is very important when authorizing requests for distributions.

Please explain how you would like to see assets in the Beneficiary's account used to improve the Beneficiary's quality of life. We may require a spending plan under certain circumstances. If so, we will let you know. If so, we will let you know. Please note that you will NOT be limited to only those items or services listed here.

Please fill out the questions below to assist in the distribution process.

Does the trust beneficiary have an ABLE account? ☐ **YES** ☐ **NO**

Does the trust beneficiary own a home? ☐ **YES** ☐ **NO**

If yes, please provide the address:

Does the trust beneficiary own a vehicle? ☐ **YES** ☐ **NO**

Is the trust beneficiary married? ☐ **YES** ☐ **NO**

If yes, please provide the spouse's name: _____

Does the trust beneficiary have children? ☐ **YES** ☐ **NO**

If yes, please provide their names and date of birth:

If possible, please provide the name and address of anyone who can be consulted if reassessing the Beneficiary's supplemental needs becomes useful or necessary in the future. Examples might include family members, a care manager, or even a care management company. *Please indicate whether you would like for each person to be able to request distributions*.

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Able to request distributions: **YES** ☐ **NO** ☐

Please provide contact information for the remainder beneficiaries.

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Birthdate: _____

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Birthdate: _____

Name: □ Mr./□ Ms. _____

Address: _____

_____

Telephone: _____

Email: _____ Relationship: _____

Birthdate: _____

Understanding Regarding Legal Advice and Distributions from Trust

Please **initial each item** and **sign** below to acknowledge an understanding that:

____ Neither the Non-Profit Trustee, the Co-Trustees, nor any of their employees or agents, have offered or given me any legal advice regarding the Trust, the suitability of the Trustee as it may apply to my particular circumstances or to the particular circumstances of the Beneficiary. I have been encouraged to, and have had a full, complete, and fair opportunity to, seek independent tax and legal counsel;

____ I understand there may be limitations on how funds in the trust may be utilized depending on the terms of the trust and other varying factors. We may require a spending plan under certain circumstances. If so, we will let you know;

____ Each request for a distribution must be accompanied by a Distribution Request Form (provided in the Welcome Packet) and a bill, receipt and/or proof of payment for the expenditure that solely benefits the Beneficiary;

____ If the Beneficiary is receiving Supplemental Security Income (SSI) there will be additional restrictions regarding distributions which will be detailed in the Welcome Packet;

____ If I request that an individual is to be paid for services rendered to the Beneficiary, and the individual providing these services is not in the routine business of providing such services, the individual will be paid through a third-party employment service at no additional cost to the Beneficiary;

____ I understand that the Trustee shall be compensated pursuant to their usual and customary fees. Additional fees may be assessed for individual money management, accounting services, legal services, or the management of unique assets such as real property or mineral interests.

Dated the ____ day of_____, _____.

_____

Primary Contact