THE ARC COMMUNITY TRUST OF PENNSYLVANIA

NEW TRUST INFORMATION

A. Beneficiary

1. Name _____
2. Address _____

   _____
3. Telephone: Day _____ Evening _____
4. Social Security Number _____
5. Date of Birth _____
6. Place of Birth (Hospital, City, State) _____
7. Mother's Name _____ SSN _____
8. Father's Name _____ SSN _____

9. If the Beneficiary is not living on their own, please describe the living arrangement (e.g. who is responsible for the living arrangements, who else lives with the beneficiary etc.)

_____

_____

_____

B. Settlor

1. Name _____
2. Address _____

   _____
3. Telephone: Day _____ Evening _____
4. Social Security Number _____
5. Date of Birth _____
6. Relationship to Beneficiary _____

Note: If there is more than one Settlor, please use additional pages for this information.

C. How will Trust be funded?

i. What assets will be deposited to the trust and if all funds won't come in at inception, please indicate the expected dates and amounts of subsequent deposits to the Trust.

_____

_____

ii. What is the source of the funds? _____

_____

iii. If the source of funds is a lawsuit or settlement, please identify the Attorney responsible for the resolution of the claim (including firm name, address & telephone no.).

_____

_____

iv. Have all liens associated with any personal injury claim been satisfied?

_____

D. Has DPW approval of the Trust been obtained? Y ___ N ___

If approval letter not yet been obtained, provide evidence that approval has been sought:

E. Guardians or Representatives

Please indicate whether the Beneficiary has a legal representative (e.g., legal guardian, conservator, representative payee, agent acting under a durable power of attorney, trustee, or other legal representative or fiduciary.

1. Name _____
2. Address _____

   _____
3. Title or Capacity _____
4. Telephone: Day _____ Evening _____
5. Social Security Number _____

Note: If there is more than one Legal Representative, please use additional pages for this information.

Others authorized to request disbursements on behalf of the Beneficiary:

1. **Name and Relationship** _____
2. Address _____

   _____
3. Telephone: Day _____ Evening _____

1. **Name and Relationship** _____
2. Address _____

   _____
3. Telephone: Day _____ Evening _____
4. Relationship _____

For any others, please use additional pages.

F. Income and Benefits

Please list any non-governmental sources and amounts of income that the Beneficiary receives and any resources in the Beneficiary's name.

_____

_____

Please indicate whether Beneficiary receives any of the following benefits:

Social Security ____ monthly amount _____

Social Security Disability Insurance (SSDI) ____ monthly amount _____

Supplemental Security Income (SSI) ____ monthly amount _____

Medicaid (Access Card) _____ card number _____

Please list other forms and amounts of government assistance.

_____ _____

G. Health/Medical Insurance

Please list any health insurance policies (other than Medicaid and including Medicare).

1. Insurer _____

   Address _____

   Policy Number _____

2. Insurer _____

   Address _____

   Policy Number _____

H. **Funeral Plans**

Please provide the following information if the Beneficiary is covered by any prepaid funeral or burial plan:

Insurer _____

Address _____

Policy Number _____

I. **Disability**

Please provide the following information on the Beneficiary's disability(ies):

1. Nature of the disability(ies)_____

   _____

2. Medical diagnosis, if available _____
3. Prognosis or plans _____

   _____

4. Name and address of primary care physician and, if appropriate, psychiatrist

   _____

   _____

J. **Goals for Fund:**

How do you expect the fund to be used? (Please indicate specific expenses you anticipate paying from the fund).

_____

_____

How long do you expect the fund to last to be available to meet those expenses?

_____

_____

When do you expect to begin to use the fund? _____