Guardian Community Trust

TRUST ACCOUNT INFORMATION FORM

Office Use Only

Trust EIN: ___-_____

GENERAL INFORMATION

1. Trust Details:

Name of Trust: _____

Date Account Established: _____ Opening Deposit Amount: _____

Source of Funds: <Select> _____

2. Settlor: ☐ Beneficiary is the Settlor (signing for him/herself) (Please skip to Section 3)

☐ Someone else is the Settlor— Relationship to Beneficiary: <Select>

Name: _____

Address: _____ ____ _____
Select State *Zip*

Telephone: _____ (h) _____ (c) Citizenship: <Select>

E-Mail: _____ Employer: _____

Settlor's Social Security No: _____

Settlor is acting under:

☐ Durable Power of Attorney* dated: _____

☐ Conservatorship* appointed on: _____

in <Select> County, Docket No. _____

** Please attach copy of Durable Power of Attorney or Decree for Estate Planning.*

Evidence of Disability: <Select> _____ Date Determined: _____
(Please attach copy of document)

3. Beneficiary Information:

Name: _____ Date of Birth: _____

Home Address: _____ _____ _____
Select State

☐ Female ☐ Male Telephone: _____ (h) _____ (c)

Social Security Number: _____ E-Mail: _____

Citizenship: <Select> Employer: _____

Current Living Situation:

☐ Home

☐ Assisted Living Facility

☐ Nursing Home

☐ Other: _____

Facility Information :

Name: _____

Contact Name & Title: _____

Address: _____ _____ _____
Select State

Telephone: _____

Marital Status: <Select> E-Mail: _____

Notes: _____

4. Decisional Capacity/Responsible Party (RP) Information:

☐ Beneficiary has full decisional capacity and should be consulted directly. (Please skip to Section 5.)

☐ Beneficiary acts through an RP, because —

☐ Although competent, he or she prefers to act through an RP for convenience.

☐ He or she lacks decisional capacity — ☐ always ☐ most of the time ☐ occasionally

☐ Check here if the person completing this form is the RP. Please provide your contact information on the signature page at the end of this form. Please skip to Section 5.

☐ Check here if the RP is someone else, and please provide the following information:

Name _____

Company (if any) _____

Address 1 _____

Address 2 _____ ____ _____
Select State

Phone (c) _____ (w) _____

E-Mail _____

If related, please indicate relationship:

☐ Child ☐ Grandchild

☐ Parent ☐ Sibling

☐ Nephew or Niece ☐ Cousin

☐ Other (please describe): _____

Please indicate any legal authority that the RP may have with respect to the beneficiary. The RP is:

☐ An agent under a Durable Power of Attorney dated

☐ A guardian or conservator appointed in <Select> County, Docket No. _____

☐ A family member or friend who is not a fiduciary

☐ Employee of a social services agency

☐ Other: _____

FINANCIAL INFORMATION

5. Non-Real Estate Assets

Check if copy of contract, account or title is on file:

A. Does Beneficiary have (1) pre-need funeral contract?* ☐ Yes ☐ No ☐ Unknown ☐

(2) burial expense savings account?* ☐ Yes ☐ No ☐ Unknown ☐

**** Please attach copy of pre-need funeral contract and burial expense savings account, unless you already have submitted it.***

B. Does Beneficiary own an automobile? ☐ Yes ☐ No ☐ Unknown ☐

If so: _____ Make _____ Model _____ Year _____ Mileage _____ Value

Insurance information: _____
Name of Agency

_____ Telephone _____ Address ____ *Select State* _____ Zip

6. Home Ownership

A. Does the Beneficiary own a home? ☐ Yes ☐ No ☐ Unknown *Check here if copy of Deed is on file:* ☐

If no, please skip to Section 8. If Beneficiary does own a home, please answer the following:

B. Where is the home located? _____
Street Address

_____ _____ _____
City/Town *Select State* Zip

C What type of property is the home? ☐ Single family ☐ Multi-family ☐ Condo, Co-op, or Townhouse ☐ Mobile home

If the home is a condo, townhouse, co-op or mobile home, please complete the following:

Owners Assoc. (or Park) Name:_____

Address _____ _____ _____
Select State

Contact:_____ _____ _____
Name Telephone E-Mail Address

D. How is title held?* ☐ Fee simple (no co-owners) **** Please attach copy of deed or title***

☐ Life estate --> Remaindermen are ☐ Individuals ☐ Trust ☐ Both

☐ Jointly with— Sibling(s) Children Other _____

☐ In trust * ☐ Revocable ☐ Irrevocable *Copy of Trust is in file:* ☐

Notes: _____ **** Please attach copy if not on file.***

E. Is the home insured? ☐ Yes ☐ No ☐ Unknown Insurance Contact: _____

F. Is there a mortgage on the home? ☐ Yes ☐ No ☐ Unknown Payment: _____/mo.

G. Does the Beneficiary live in the home? ☐ Yes ☐ No ☐ Unknown

If not, when was the last date that the Beneficiary did live in the home? _____

Do persons other than the Beneficiary live in the home? ☐ Yes ☐ No ☐ Unknown

If so, please provide name, age, relationship and years living there: _____

_____

7. Home Ownership Expenses

_____

Mortgage: $_____/mo. Lawn care & snow removal: $_____/mo.

Real estate taxes: $_____/mo. Other: _____ $_____/mo.

Insurance: $_____/mo. Other: _____ $_____/mo.

Notes: _____ 0

Please note that when Beneficiary does not live in the home, the trust CANNOT pay home expenses, if:

(1) *Anyone else lives there, whether related or not. Occupant pays all expenses, directly or via rent.*

(2) *Beneficiary retains only a Life Estate, whether someone else lives there or not.*

(3) *The amount in the trust account is not enough to sustain payment of the expenses, plus other anticipated needs of Beneficiary, for his or her acturially-based life expectancy.*

These policies can be modified, to a limited extent and for a short time, depending on circumstances.

INCOME & BENEFITS

8. Earned Income from Work or Military Service. Please check off & fill in amounts for all types that apply.

☐ Income from current employment: $_____/mo.

Name of employer: _____

Employer contact: _____ _____ _____

Name *Title/Position* *Telephone*

☐ Social Security Disability (SSDI) or Retirement Income (but **NOT SSI**): $_____/mo.
(see below)

☐ Pension from state or private employment: $_____/mo.

☐ VA Pension (but **NOT** Aide & Attendance): $_____/mo.

☐ Other: _____ $_____/mo.

9. Public Benefits (but **NOT SSDI**-*see above)*

A. Income (please check and fill in amounts for all types that apply):

☐ Supplemental Security Income (SSI) (but **NOT SSDI**-*see above)*: $_____/mo.

☐ TAFDC (Temporary Aid to Families with Dependent Children): $_____/mo.

☐ VA Aid & Attendance Income: $_____/mo.

☐ Other: _____ $_____/mo.

B. In-Kind Support (please check and fill in MONTHLY amounts for all types that apply:

☐ Food Stamps (include total for all household members): $_____/mo.

☐ Heating oil: $_____/mo.

☐ Other: _____ $_____/mo.

C. Housing (please check applicable program, MARKET RENT and NET RENT after subsidy):

	If Section 8, check one:	***Rent***	***Market Rate***	***Benefit***
☐ Section 8:	☐ Project-based ☐ Voucher	$_____/mo.	$_____/mo.	$ 0 /mo.
☐ Subsidized housing for elders or disabled:		$_____/mo.	$_____/mo.	$ 0 /mo.
☐ Low-income tenant unit in assisted living:		$_____/mo.	$_____/mo.	$ 0 /mo.
☐ PACE or GAFC in assisted living:		$_____/mo.	$_____/mo.	$ 0 /mo.
☐ Other: _____		$_____/mo.	$_____/mo.	$ 0 /mo.

Agency that administers housing benefit: _____

Name of person in charge of benefit: _____

Street Address: _____

City/State/Zip: _____ MA _____
Select State

Telephone: _____ E-mail: _____

Total Income and Benefits: . . . . . *Including value of housing subsidy*: $ 0 /mo.

Not including value of housing subsidy: $ 0 /mo.

10. Beneficiary's Known and Anticipated 9ÈŁJŜyãŜă (other than home ownership)

A. Please complete if Beneficiary resides in **nursing home (skilled nursing care facility)**—

☐ Patient-Paid Amount: . . . . . $_____/mo.

☐ Bedside telephone: . . . . . $_____/mo.

☐ Cable television: . . . . . $_____/mo.

B. Please complete if Beneficiary resides **in apartment, assisted living or other community setting**—

☐ Rent — (1) Subsidized: . . . $_____0/mo

(2) Non-Subsidized: $_____/mo. Total: $_____0_____/mo.

☐ Gas or Oil (or other Heating expense): . . . . . $_____/mo.

☐ Electricity: . . . . . $_____/mo.

☐ Cable (TV, phone and/or internet): . . . . . $_____/mo.

C. Automobile—

☐ Insurance: $_____/ mo.

☐ Gas/tires: $_____/mo.

☐ Parking: $_____/mo.

Other auto expense—

☐ _____ $_____/mo.

☐ _____ $_____/mo.

☐ _____ $_____/mo.

D. Professional Services—

☐ Legal and financial: . . . . . $_____/mo. $ _____/yr.

☐ Social services, including case management: $_____/mo. $ _____/yr.

☐ Personal care: . . . . . $_____/mo. $ _____/yr.

E. Personal expenses—

☐ Clothing: $_____/mo.

☐ Subscriptions: $_____/mo.

☐ Books/movies: $_____/mo.

☐ Travel: $_____/mo.

Other personal expense—

☐ _____ $_____/mo.

☐ _____ $_____/mo.

☐ _____ $_ _____/mo.

☐ _____ $_ _____/mo.

F. Miscellaneous—

☐ _____ $_____/mo.

☐ _____ $_____/mo.

☐ _____ $_____/mo.

☐ _____ $_____/mo.

☐ _____ $_____/mo.

Total Expenses: . . . . . *Including real estate or rental costs*: $_____0/mo.

Not including real estate or rental costs: $_____/mo.

Notes: _____

_____

_____

11. Social and Clinical Information

A. If diagnosis is dementia, what is the Beneficiary's level of functioning?

(1) ☐ Fully able to communicate; or - - - - - -> (2) ☐ Intermittently engages in conversation; or

(3) ☐ Some communication but can't engage in conversation - - -> (4) ☐ No ability to communicate

B. Are the family members a reliable reporter of the Beneficiary's—

Level of understanding of medical information?	☐ Yes	☐ No	☐ Unknown
Level of understanding of financial information?	☐ Yes	☐ No	☐ Unknown
Judgment as to medical issues?	☐ Yes	☐ No	☐ Unknown
Judgment as to financial issues?	☐ Yes	☐ No	☐ Unknown

Notes: _____

C. Local social support: ☐ Strong ☐ Weak ☐ Nonexistent

Source: ☐ Family_____ ☐ Friend ☐ Professional_____

Frequency of contact: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

D. Does beneficiary belong to an organized community of any kind? ☐ Yes ☐ No ☐ Unknown

If so, what kind? ☐ Interest-based ☐ Mental health- or disability-related ☐ Religiously-based

Notes: _____

E. Isolation factors: (1) Tends to spend time: ☐ Alone ☐ With a community
(2) Identified barriers to community participation:

_____

_____

F. Medical care management concerns

☐ Dietary issues ☐ Chronic medical issues ☐ Mental illness

Notes: _____

_____

G. Beneficiary's goals:

Short-term: Long-term:

_____ _____

_____ _____

_____ _____

H. General/Miscellaneous Clinical Notes:

_____

_____

CONTACTS

12. Persons involved, other than the person(s) completing this form. Please include family members, case managers, therapists, attorneys, doctors, important friends, etc.

ATTORNEY: _____
Firm: _____
Address 1: _____
Address 2: _____
City/St/Zip: _____ ___ _____
Select State
Phone: _____
E-mail: _____

(1) NAME: _____
Company: _____
Relationship: _____
Street Address: _____
City/St/Zip: _____ ___ _____
Select State
Phone: _____
E-mail: _____

(2) NAME: _____
Company: _____
Relationship: _____
Street Address: _____
City/St/Zip: _____ ___ _____
Select State
Phone: _____
E-mail: _____

(3) NAME: _____
Company: _____
Relationship: _____
Street Address: _____
City/St/Zip: _____ ___ _____
Select State
Phone: _____
E-mail: _____

(4) NAME: _____
Company: _____
Relationship: _____
Street Address: _____
City/St/Zip _____ ___ _____
Select State
Phone: _____
E-mail: _____

(5) NAME: _____
Company: _____
Relationship: _____
Street Address: _____
City/St/Zip: _____ ___ _____
Select State
Phone: _____
E-mail: _____

10. Other information, comments or components of Trust:

_____

_____

_____

_____

_____

_____

_____

12. Signature(s). Person(s) completing this form: Please provide the information below, and sign.

Name ☐ *(I am the Beneficiary)* ☐ *(I am not the Beneficiary)*

Company or Other Organization

Address

City/Town Select State Zip

Cell Phone Work Phone

Landline Other Phone

E-Mail Address

If you are not the beneficiary, please indicate your relationship:

- ☐ Child
- ☐ Grandchild
- ☐ Nephew or Niece
- ☐ Parent
- ☐ Sibling
- ☐ Cousin
- ☐ Other (please describe): _____

Signed:

_____ Date: _____

Print Name: _____

Additional Signer *If information about additional signer is in Contacts, complete only the "Second Signature" section, below.*

Name

Company or Other Organization

Address

City/Town MA State Zip

Cell Phone Work Phone

Landline Other Phone

E-Mail Address

If related, please indicate relationship:

- ☐ Child
- ☐ Grandchild
- ☐ Nephew or Niece
- ☐ Parent
- ☐ Sibling
- ☐ Cousin
- ☐ Other (please describe): _____

Second Signature:

_____ Date: _____

Print Name: _____

Received by Guardian Community Trust:

_____ **by** _____

Date <Select>